



**Los Angeles County Tuberculosis Control
Guidelines for the Investigation of Contacts of
Persons with Infectious Tuberculosis
2013**

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Introduction

This document contains addenda to the Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis, Recommendations from the National Tuberculosis Controllers Association (NTCA) and Centers for Disease Control and Prevention (CDC) (2005 national guidelines) and was developed by representatives of the California Department of Public Health (CDPH)-Tuberculosis Control Branch (TBCB) and California Tuberculosis Controllers Association (CTCA). The addenda, consisting of additions, clarifications and appendices, reflect the position of CDPH-TBCB and the CTCA membership and their purpose is to increase the utility of the 2005 national guidelines for tuberculosis control practice in California.

Methodology:

In developing this document the LAC DPH TB Control Program (TBCP) Contact Investigation (CI) manual/standards revision workgroup was faced with two main options:

1. Write a completely new set of guidelines incorporating both the 2005 national guidelines and 2011 CDPH/CTCA Joint Guidelines on Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis
2. Adopt the 2011 CDPH/CTCA Joint Guidelines on Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis

After systematic review and comparison of the 2005 national guidelines and 2011 CDPH/CTCA Joint guidelines, the workgroup decided to adopt the 2011 CDPH/CTCA Joint guidelines in principle with additional appendices to clarify and outline points unique to TB Control in LAC (Updated Section 'L' of the 2003 TB Manual). In addition, LAC DPH TBCP revised the 2003 LAC TB Manual Chapter 6 (Contact Investigation) to reflect major updates and provide algorithms and tools to aid the CI Core Team in completing CI tasks. For the future, the plan is to continue to further edit and modify the document in order to make it more user-friendly.

Approval:

LAC DPH TBCP adopted the 2011 CDPH/CTCA addenda to the 2005 national guidelines and endorsed this updated guidelines on 8.1.2013. The revised Chapter 6 and this document supersede the 2003 LAC TB Manual Chapter 6 and Appendix L 1997 LAC CI standards.

Scope:

The LAC DPH TBCP addenda are intended to be advisory and may not cover every situation. Each contact investigation should be evaluated individually and decisions for action made on a case-by-case basis, and, when appropriate, after expert consultation.

Format:

1. The text of the original 2005 national guidelines was not changed.
2. LAC DPH TBCP recommendations were added to support and clarify CDPH/CTCA addenda where pertinent. LAC DPH TBCP addenda are highlighted in blue boxes below the CDPH/CTCA numbered addenda. Hyperlinks within CDPH/CTCA were updated where necessary.
3. Appendices are attached and are listed in the Table of Contents.
4. Requirements of the California Health & Safety Code, the California Code of Regulations (CCR), Title 22, and the California Occupational Safety and Health Administration (Cal/OSHA) are cited where applicable.
5. Finally, electronic resources are referenced in appropriate sections.

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Addendum 2

Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis

Recommendations from the National Tuberculosis Controllers Association and CDC

The material in this report originated in the National Center for HIV, STD, and TB Prevention, Kevin Fenton, MD, PhD, Director, and the Division of Tuberculosis Elimination, Kenneth G. Castro, MD, Director.

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Summary

In 1976, the American Thoracic Society (ATS) published brief guidelines for the investigation, diagnostic evaluation, and medical treatment of TB contacts. Although investigation of contacts and treatment of infected contacts is an important component of the U.S. strategy for TB elimination, second in priority to treatment of persons with TB disease, national guidelines have not been updated since 1976.

This statement, the first issued jointly by the National Tuberculosis Controllers Association and CDC, was drafted by a working group consisting of members from both organizations on the basis of a review of relevant epidemiologic and other scientific studies and established practices in conducting contact investigations. This statement provides expanded guidelines concerning investigation of TB exposure and transmission and prevention of future cases of TB through contact investigations. In addition to the topics discussed previously, these expanded guidelines also discuss multiple related topics (e.g., data management, confidentiality and consent, and human resources). These guidelines are intended for use by public health officials but also are relevant to others who contribute to TB control efforts. Although the recommendations pertain to the United States, they might be adaptable for use in other countries that adhere to guidelines issued by the World Health Organization, the International Union against Tuberculosis and Lung Disease, and national TB control programs.

Introduction

Background

In 1962, isoniazid (INH) was demonstrated to be effective in preventing tuberculosis (TB) among household contacts of persons with TB disease (1). Investigations of contacts and treatment of contacts with latent TB infection (LTBI) became a strategy in the control and elimination of TB (2,3). In 1976, the American Thoracic Society (ATS) published brief guidelines for the investigation, diagnostic evaluation, and medical treatment of TB contacts (4). Although investigation of contacts and treatment of infected contacts is an important

component of the U.S. strategy for TB elimination, second in priority to treatment of persons with TB disease, national guidelines have not been updated since 1976.

This statement, the first issued jointly by the National Tuberculosis Controllers Association (NTCA) and CDC, was drafted by a working group consisting of members from both organizations on the basis of a review of relevant epidemiologic and other scientific studies and established practices in conducting contact investigations. A glossary of terms and abbreviations used in this report is provided (Box 1 and Appendix A).

BOX 1. Terms* and abbreviations used in this report

Acid-fast bacilli (AFB)	Laryngeal TB
Allergy	Latent tuberculosis infection [LTBI]
Associate contact	Mantoux method
Bacille Calmette-Guerin (BCG)	Meningeal TB
Boosting	Miliary TB
Bronchoscopy	Molecular Beacon
Bronchoalveolar lavage (BAL)	Multidrug-resistant TB (MDR TB)
Case	<i>Mycobacterium bovis</i>
Cavity (pulmonary)	<i>Mycobacterium tuberculosis (M. tuberculosis)</i>
Contact	Nucleic acid amplification (NAA)
Contagious	Purified protein derivative (PPD) tuberculin
Conversion	Quantiferon [®] -TB test (QFT)
Delayed-type hypersensitivity (DTH)	QuantiFERON [®] -TB Gold test (QFT-G)
Directly observed therapy (DOT)	Radiography
Drug-susceptibility test	Secondary (TB) case
Enabler	Secondary (or "second-generation") transmission
Exposure	Smear
Exposure period	Source case or patient
Exposure site	Specimen
Extensively drug-resistant TB (XDR-TB)	Sputum
Immunocompromised and immunosuppressed	Suspected TB
Incentive	Symptomatic TB disease
Index	Treatment for (or of) latent (<i>M. tuberculosis</i>) infection
Induration	Tuberculin
Infection	Tuberculin skin test (TST)
Infectious	Tuberculin skin test conversion
Infectious period	Tuberculosis (TB)
Interferon-γ Release Assay (IGRA)	Two-step (tuberculin) skin test
Isoniazid (INH)	
*Terms listed are defined in the glossary (Appendix A)	

Addendum 3

This statement provides expanded guidelines concerning investigation of TB exposure and transmission and prevention of future cases of TB through contact investigations. In addition to the topics discussed previously, these expanded guidelines also discuss multiple related topics (e.g., data management, confidentiality and consent, and human resources). These guidelines are intended for use by public health officials but also are relevant to others who contribute to TB control efforts. Although the recommendations pertain to the United States, they might be adaptable for use in other countries that adhere to guidelines issued by the World Health Organization, the International Union Against Tuberculosis and Lung Disease, and national TB control programs.

Contact investigations are complicated undertakings that typically require hundreds of interdependent decisions, the majority of which are made on the basis of incomplete data, and dozens of time-consuming interventions. Making successful decisions during a contact investigation requires use of a complex, multifactor matrix rather than simple decision trees. For each factor, the predictive value, the relative contribution, and the interactions with other factors have been incompletely studied and understood. For example, the differences between brief, intense exposure to a contagious patient and lengthy, low-intensity exposure are unknown.

Studies have confirmed the contribution of certain factors: the extent of disease in the index patient, the duration that the source and the contact are together and their proximity, and local air circulation (5). Multiple observations have demonstrated that the likelihood of TB disease after an exposure is influenced by medical conditions that impair immune competence, and these conditions constitute a critical factor in assigning contact priorities (6).

Other factors that have as yet undetermined importance include the infective burden of *M. tuberculosis*, previous exposure and infection, virulence of the particular *M. tuberculosis* strain, and a contact's intrinsic predisposition for infection or disease. Further, precise measurements (e.g., duration of exposure) rarely are obtainable under ordinary circumstances, and certain factors (e.g., proximity of exposure) can only be approximated, at best.

No safe exposure time to airborne *M. tuberculosis* has been established. If a single bacterium can initiate an infection leading to TB disease, then even the briefest exposure entails a theoretic risk. However, public health officials must focus their resources on finding exposed persons who are more likely to be infected or to become ill with TB disease. These guidelines establish a standard framework for assembling information and using the findings to inform decisions for contact investigations, but they do not diminish the value of experienced judgment that is required. As a practical matter, these guidelines also take into consideration the scope of resources (primarily personnel) that can be allocated for the work.

Methodology

A working group consisting of members from the NTCA and CDC reviewed relevant epidemiologic and other scientific studies and established practices in conducting contact investigations to develop this statement. These published studies provided a scientific basis for the recommendations. Although a controlled trial has demonstrated the efficacy of treating infected contacts with INH (1), the effectiveness of contact investigations has not been established by a controlled trial or study. Therefore, the recommendations (Appendix B) have not been rated by quality or quantity of the evidence and reflect expert opinion derived from common practices that have not been tested critically.

These guidelines do not fit every circumstance, and additional considerations beyond those discussed in these guidelines must be taken into account for specific situations. For example, unusually close exposure (e.g., prolonged exposure in a small, poorly ventilated space or a congregate setting) or exposure among particularly vulnerable populations at risk for TB disease (e.g., children or immunocompromised persons) could justify starting an investigation that would normally not be conducted. If contacts are likely to become unavailable (e.g., because of departure), then the investigation should receive a higher priority. Finally, affected populations might experience exaggerated concern regarding TB in their community and demand an investigation.

Structure of this Statement

The remainder of this statement is structured in 13 sections, as follows:

- **Decisions to initiate a contact investigation.** This section focuses on deciding when a contact investigation should be undertaken. Index patients with positive acid-fast bacillus (AFB) sputum-smear results or pulmonary cavities have the highest priority for investigation. The use of nucleic acid amplification (NAA) tests is discussed in this context.
- **Investigating the index patient and sites of transmission.** This section outlines methods for investigating the index patient. Topics discussed include multiple interviews, definition of an infectious period, multiple visits to places that the patient frequented, and the list of contacts (i.e., persons who were exposed).
- **Assigning priorities to contacts.** This section presents algorithms for assigning priorities to individual contacts for evaluation and treatment. Priority ranking is determined by the characteristics of individual contacts and the features of the exposure. When exposure is related to households, congregate living settings, or cough-inducing medical procedures, contacts are designated as high priority. Because knowledge is insufficient for providing exact recommendations, cut-off points for duration of exposure are not included; state and local program officials should determine cut-off points after considering published results, local experience, and these guidelines.

- **Diagnostic and public health evaluation of contacts.** This section discusses diagnostic evaluation, including specific contact recommendations for children aged <5 years and immunocompromised persons, all of whom should be evaluated with chest radiographs. The recommended period between most recent exposure and final tuberculin skin testing has been revised; it is 8–10 weeks, not 10–15 weeks as recommended previously (4).
- **Medical treatment for contacts with LTBI.** This section discusses medical treatment of contacts who have LTBI (6,7). Effective contact investigations require completion of therapy, which is the single greatest challenge for both patients and health-care providers. Attention should be focused on treating contacts who are assigned high or medium priority.
- **When to expand a contact investigation.** This section discusses when contacts initially classified as being a lower priority should be reclassified as having a higher priority and when a contact investigation should be expanded. Data regarding high- and medium-priority contacts inform this decision.
- **Communicating through the media.** This section outlines principles for reaching out to media sources. Media coverage of contact investigations affords the health department an opportunity to increase public knowledge of TB control and the role of the health department.
- **Data management and evaluation of contact investigations.** This section is the first of three to address health department programmatic tasks. It discusses data management, with an emphasis on electronic data storage and the use of data for assessing the effectiveness of contact investigations.
- **Confidentiality and consent in contact investigations.** This section introduces the interrelated responsibilities of the health department in maintaining confidentiality and obtaining patient consent.
- **Staffing and training for contact investigations.** This section summarizes personnel requirements and training for conducting contact investigations.
- **Contact investigations in special circumstances.** This section offers suggestions for conducting contact investigations in special settings and circumstances (e.g., schools, hospitals, worksites, and congregate living quarters). It also reviews distinctions between a contact investigation and an outbreak investigation.
- **Source-case investigations.** This section addresses source-case investigations, which should be undertaken only when more urgent investigations (see Decisions to Initiate a Contact Investigation) are being completed successfully. The effectiveness and outcomes of source-case investigations should be monitored critically because of their general inefficiency.
- **Other topics.** This section reviews three specialized topics: cultural competency, social network analysis, and recently approved blood tests. Newly approved blood tests for the

diagnosis of *M. tuberculosis* infection have been introduced. If these tests prove to be an improvement over the tuberculin skin test (TST), the science of contact investigations will advance quickly.

Decisions to Initiate a Contact Investigation

Competing demands restrict the resources that can be allocated to contact investigations. Therefore, public health officials must decide which contact investigations should be assigned a higher priority and which contacts to evaluate first (see Assigning Priorities to Contacts). A decision to investigate an index patient depends on the presence of factors used to predict the likelihood of transmission (Table 1). In addition, other information regarding the index patient can influence the investigative strategy.

TABLE 1. Characteristics of the index patient and behaviors associated with increased risk for tuberculosis (TB) transmission

Characteristic	Behavior
Pulmonary, laryngeal or pleural TB	Frequent coughing
AFB* positive sputum smear	Sneezing
Cavitation on chest radiograph	Singing
Adolescent or adult patient	Close social network
No or ineffective treatment of TB disease	

**Acid-fast bacilli.*

Factors that Predict Likely Transmission of TB

Anatomical Site of Disease

With limited exceptions, only patients with pulmonary or laryngeal TB can transmit their infection (8,9). For contact investigations, pleural disease is grouped with pulmonary disease because sputum cultures can yield *M. tuberculosis* even when no lung abnormalities are apparent on a radiograph (10).

CDPH/CTCA supports the investigation of contacts to cases of pleural TB.

Addendum 4

LAC DPH TBCP supports the investigation of contacts to cases with pleuro-pulmonary disease (pleural TB disease with concomitant pulmonary TB disease). For a pleural TB suspect or case, pulmonary involvement should always be excluded with chest X-ray and sputum for AFB smear and culture. When a case is suspected to have exclusively pleural disease, and sputum smears are AFB negative, a contact investigation can be deferred while awaiting culture results. If all sputum cultures are negative, then a contact investigation does not need to be performed.

Rarely, extrapulmonary TB causes transmission during medical procedures that release aerosols (e.g., autopsy, embalming, and irrigation of a draining abscess) (see Contact Investigations in Special Circumstances) (11–15)

Sputum Bacteriology

Relative infectiousness has been associated with positive sputum culture results and is highest when the smear results are also positive (16–19). The significance of results from respiratory specimens other than expectorated sputum (e.g., bronchial washings or bronchoalveolar lavage fluid) is undetermined. Experts recommend that these specimens be regarded as equivalent to sputum (20).

Radiographic Findings

Patients who have lung cavities observed on a chest radiograph typically are more infectious than patients with noncavitary pulmonary disease (15,16,21). This is an independent predictor after bacteriologic findings are taken into account. The importance of small lung cavities that are detectable with computerized tomography (CT) but not with plain radiography is undetermined. Less commonly, instances of highly contagious endobroncheal TB in severely immunocompromised patients who temporarily had normal chest radiographs have contributed to outbreaks. The frequency and relative importance of such instances is unknown, but in one group of human immunodeficiency virus (HIV)–infected TB patients, 3% of those who had positive sputum smears had normal chest radiographs at the time of diagnosis (22,23).

Behaviors That Increase Aerosolization of Respiratory Secretions

Cough frequency and severity are not predictive of contagiousness (24).

CDPH/CTCA recognizes that some studies suggest cough frequency may predict contagiousness and the statement that cough frequency is not predictive of contagiousness contradicts Table 1. Symptoms (including cough) and behaviors of the source case should be considered in the decision to initiate a contact investigation.

Addendum 5

LAC DPH TBCP supports CDPH/CTCA Addendum 5.

However, singing is associated with TB transmission (25–27). Sociability of the index patient might contribute to contagiousness because of the increased number of contacts and the intensity of exposure.

Age

Transmission from children aged <10 years is unusual, although it has been reported in association with the presence of pulmonary forms of disease typically reported in adults (28,29). Contact investigations concerning pediatric cases should be undertaken only in such unusual circumstances (see Source-Case Investigations).

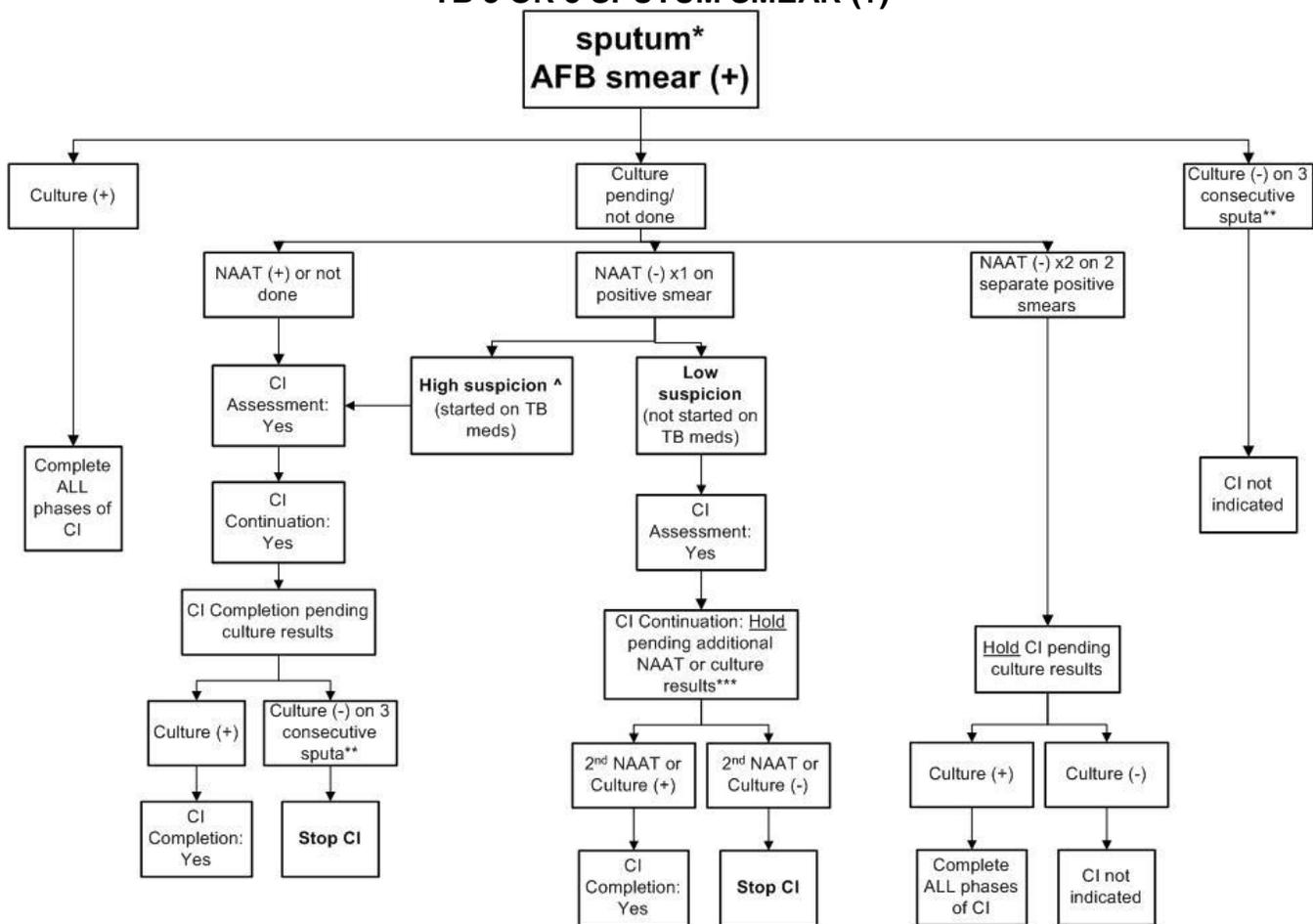
HIV Status

TB patients who are HIV-infected with low CD4 T-cell counts frequently have chest radiographic findings that are not typical of pulmonary TB. In particular, they are more likely than TB patients who are not HIV-infected to have mediastinal adenopathy and less likely to have upper-lobe infiltrates and cavities (30). Atypical radiographic findings increase the potential for delayed diagnosis, which increases transmission. However, HIV-infected patients who have pulmonary or laryngeal TB are, on average, as contagious as TB patients who are not HIV-infected (31, 32).

Administration of Effective Treatment

That TB patients rapidly become less contagious after starting effective chemotherapy has been corroborated by measuring the number of viable *M. tuberculosis* organisms in sputa and by observing infection rates in household contacts (33–36). However, the exact rate of decrease cannot be predicted for individual patients, and an arbitrary determination is required for each. Guinea pigs exposed to exhaust air from a TB ward with patients receiving chemotherapy were much more likely to be infected by drug-resistant organisms (8), which suggests that drug resistance can delay effective bactericidal activity and prolong contagiousness.

**Addendum 6 - Figure 1a. Criteria for Initiating Contact Investigation (1)
TB 3 OR 5 SPUTUM SMEAR (+)**



CI assessment –

- DPHN completes PHN TB assessment, interviews index patient or proxy to elicit contact names and locating information, identifies exposure sites and creates a preliminary CI plan (prioritizing sites, setting and contacts)
- DPHN has the flexibility to begin testing of household contacts (unless the index patient resides in a congregate residential facility)
- DPHN presents all initial information gathered on the index and preliminary CI plan to CI Core Team for review

CI Continuation –

- AMD or designee contacts administration of exposure site(s)
- DPHN, in consultation with the CI Core Team, conducts site visit(s), identifies contacts, prioritizes contacts (high, medium, low), begins initial testing (TST/IGRA) of high and medium priority contacts, schedules CXR, refers for window period prophylaxis/LTBI treatment as necessary
- If the DPHN identifies contacts outside of the district of residence (DOR) of the index patient then the DPHN refers them to the appropriate public health center or public health jurisdiction
- Interpretation of data should be carried out at a minimum by the CI Core Team after initial testing, after second round testing and at final review. Additional reviews may be necessary throughout the investigation.
- CI Core Team determines the need for expansion on an on-going basis
- DPHN documents initiation of treatment for those contacts diagnosed with LTBI

CI Completion –

- DPHN completes testing of contacts (as needed)
- DPHN monitors and documents completion of treatment for those contacts diagnosed with LTBI
- CI Core Team conducts a comprehensive analysis of the CI (see section 9) at the completion of the investigation

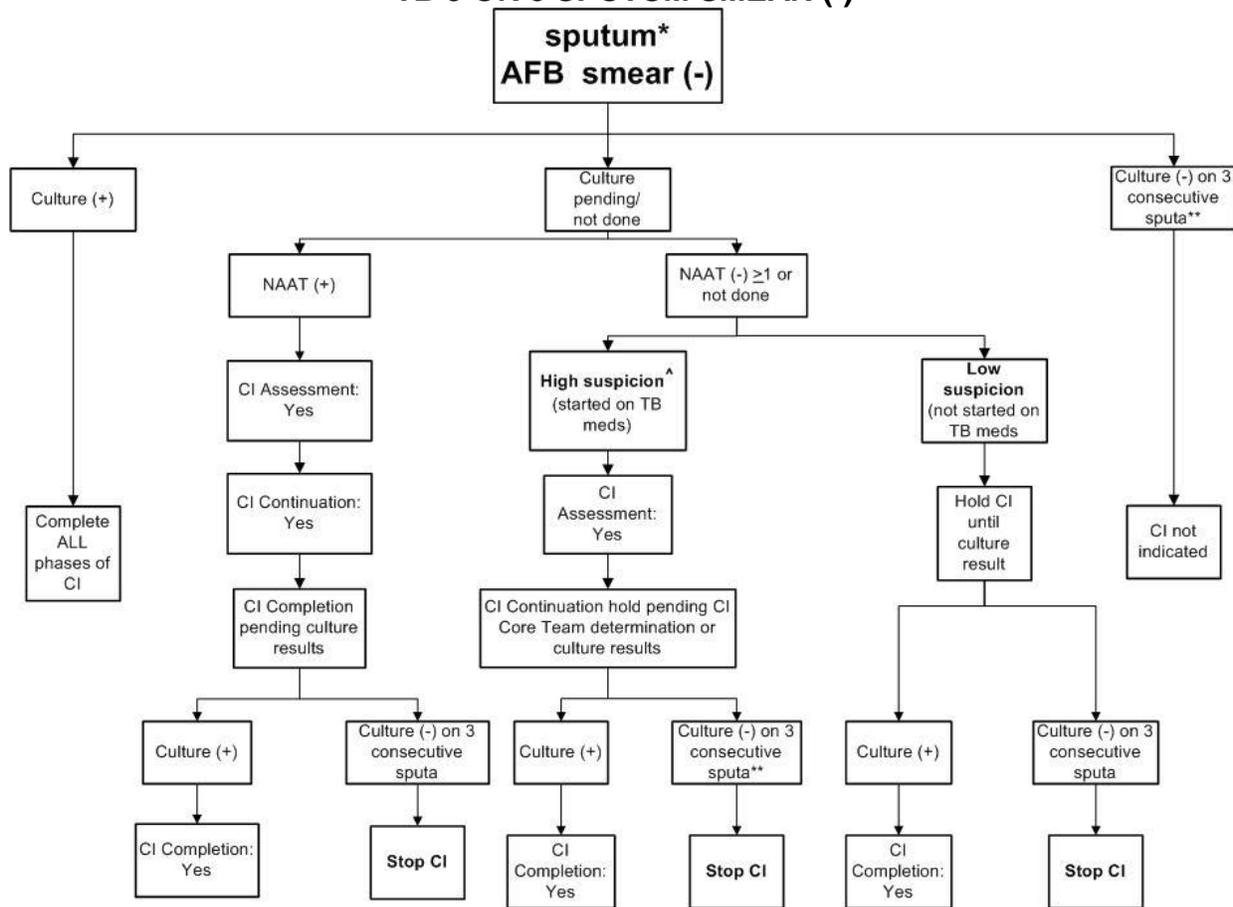
* 'Sputum' refers to sputum, bronchial washing or bronchoalveolar lavage fluid

** If patient is unable to produce 3 sputum specimens, then all sputum specimens assessed should be culture negative for Mtb (document in chart, 'all cultures performed are negative for Mtb')

***Refer to 2012 LAC TBCP NAAT guidelines

^ If meds are stopped (based on a change in diagnosis) then reassess need for CI

**Addendum 6 - Figure 1b. Criteria for Initiating Contact Investigation (2)
TB 3 OR 5 SPUTUM SMEAR (-)**



CI assessment –

- DPHN completes PHN TB assessment, interviews index patient or proxy to elicit contact names and locating information, identifies exposure sites and creates a preliminary CI plan (prioritizing sites, setting and contacts)
- DPHN has the flexibility to begin testing of household contacts (unless the index patient resides in a congregate residential facility)
- DPHN presents all initial information gathered on the index and preliminary CI plan to CI Core Team for review

CI Continuation –

- AMD or designee contacts administration of exposure site(s)
- DPHN, in consultation with the CI Core Team, conducts site visit(s), identifies contacts, prioritizes contacts (high, medium, low), begins initial testing (TST/IGRA) of high and medium priority contacts, schedules CXR, refers for window period prophylaxis/LTBI treatment as necessary
- If the DPHN identifies contacts outside of the district of residence (DOR) of the index patient then the DPHN refers them to the appropriate public health center or public health jurisdiction
- Interpretation of data should be carried out at a minimum by the CI Core Team after initial testing, after second round testing and at final review. Additional reviews may be necessary throughout the investigation.
- CI Core Team determines the need for expansion on an on-going basis
- DPHN documents initiation of treatment for those contacts diagnosed with LTBI

CI Completion –

- DPHN completes testing of contacts (as needed)
- DPHN monitors and documents completion of treatment for those contacts diagnosed with LTBI
- CI Core Team conducts a comprehensive analysis of the CI (see section 9) at the completion of the investigation

* 'Sputum' refers to sputum, bronchial washing or bronchoalveolar lavage fluid

** If patient is unable to produce 3 sputum specimens, then all sputum specimens assessed should be culture negative for Mtb (document in chart, 'all cultures performed are negative for Mtb')

***Refer to 2012 LAC TBCP NAAT guidelines

^ If meds are stopped (based on a change in diagnosis) then reassess need for CI

A contact investigation should be considered if the index patient has confirmed or suspected pulmonary, laryngeal, or pleural TB (Addendum 6, Figure 1a and 1b). An investigation is recommended if the sputum smear has AFB on microscopy, unless the result from an approved NAA test (Amplified *Mycobacterium tuberculosis* Direct Test [MTD], GenProbe[®], San Diego, California, and Amplicor[®] *Mycobacterium tuberculosis* Test [Amplicor], Roche[®] Diagnostic Systems Inc., Branchburg, New Jersey) for *M. tuberculosis* is negative (37).

The molecular beacon test used in the CDPH Microbial Diseases Laboratory (MDL) is a type of NAA test and has a high specificity for identification of *M. tuberculosis* complex in smear positive specimens (1+ or greater) or positive cultures. This test is also able to identify common mutations associated with isoniazid and rifampin resistance. Additional information can be found at:

<http://www.cdph.ca.gov/programs/tb/Documents/TBCB-MoBeacon-Testing-Descript-02-11-08.pdf> or <http://www.cdph.ca.gov/programs/tb/Documents/TBCB-MoBeaconsArticle.pdf>

Addendum 7

LAC DPH TBCP supports the use of rapid molecular testing in assessing if a CI should be continued. CDPH MDL has replaced the use of the molecular beacon test for a more rapid, sensitive and specific molecular approach. This real-time PCR and pyrosequencing assay combines the detection of TB and the identification of mutations within the TB DNA for possible drug resistance from clinical samples. LAC PHL is currently in the process of validating the real-time PCR and pyrosequencing assay.

LAC DPH TBCP wants to clarify that the Roche Amplicor test is no longer available and LAC PHL is currently using the GenProbe MTD test (NAAT).

If AFB are not detected by microscopy of three sputum smears, an investigation still is recommended if the chest radiograph (i.e., the plain view or a simple tomograph) indicates the presence of cavities in the lung.

Parenchymal cavities of limited size that can be detected only by computerized imaging techniques (i.e., CT, computerized axial tomography scan, or magnetic resonance imaging of the chest) are not included in this recommendation.

When sputum samples have not been collected, either because of an oversight or as a result of the patient's inability to expectorate, results from other types of respiratory specimens (e.g., gastric aspirates or bronchoalveolar lavage) may be interpreted in the same way as in the above recommendations. However, whenever feasible, sputum samples should be collected (through sputum induction, if necessary) before initiating chemotherapy.

Contact investigations of persons with AFB smear or culture-positive sputum and cavitary TB are assigned the highest priority. However, even if these conditions are not present, contact investigations should be considered if a chest radiograph is consistent with pulmonary TB. Whether to initiate other investigations depends on the availability of resources to be allocated and achievement of objectives for higher priority contact investigations. A positive result from an approved NAA test supports a decision to initiate an investigation. Because waiting for a sputum or respiratory culture result delays initiation of contact investigations, delay should be avoided if any contacts are especially vulnerable or susceptible to TB disease (see Assigning Priorities to Contacts).

Investigations typically should not be initiated for contacts of index patients who have suspected TB disease and minimal findings in support of a diagnosis of pulmonary TB. Exceptions can be justified during outbreak investigations (see Contact Investigations in Special Circumstances), especially when vulnerable or susceptible contacts are identified or during a source-case investigation (see Source-Case Investigations).

Investigating the Index Patient and Sites of Transmission

Comprehensive information regarding an index patient is the foundation of a contact investigation. This information includes disease characteristics, onset time of illness, names of contacts, exposure locations, and current medical factors (e.g., initiation of effective treatment and drug susceptibility results). Health departments are responsible for conducting TB contact investigations. Having written policies and procedures for investigations improve the efficiency and uniformity of investigations.

Establishing trust and consistent rapport between public health workers and patients is critical to gain full information and long-term cooperation during treatment. Good interview skills can be taught and learned skills improved with practice. Workers assigned these tasks should be trained in interview methods and tutored on the job (see Staffing and Training for Contact Investigations and Contact Investigations in Special Situations).

The majority of TB patients in the United States were born in other countries, and their fluency in English often is insufficient for productive interviews to be conducted in English. Patients should be interviewed by persons who are fluent in their primary language. If this is not possible, health departments should provide interpretation services.

Preinterview Phase

Background information regarding the patient and the circumstances of the illness should be gathered in preparation for the first interview. One source is the current medical record (38). Other sources are the physician who reported the case and (if the patient is in a hospital) the infection control nurse. The information in the medical record can be disclosed to public health authorities under exemptions in the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (<http://aspe.hhs.gov/admsimp/pl104191.htm>) (39). The

patient's name should be matched to prior TB registries and to the surveillance database to determine if the patient has been previously listed.

Multiple factors are relevant to a contact investigation, including the following:

- history of previous exposure to TB,
- history of previous TB disease and treatment,
- anatomical sites of TB disease,
- symptoms of the illness,
- date of onset,
- chest radiograph results,
- other results of diagnostic imaging studies,
- diagnostic specimens that were sent for histologic or bacteriologic analysis (with dates, specimen tracking numbers, and destinations),
- current bacteriologic results,
- anti-TB chemotherapy regimen (with dates, medications, dosages, and treatment plan),
- results from HIV testing,
- the patient's concurrent medical conditions (e.g., renal failure implies that a renal dialysis center might be part of the patient's recent experience),
- other diagnoses (e.g., substance abuse, mental illness, or dementia) that impinge directly on the interview, and
- identifying demographic information (e.g., residence, employment, first language, given name and street names, aliases, date of birth, telephone numbers, other electronic links, and next-of-kin or emergency connections).

Determining the Infectious Period

Determining the infectious period focuses the investigation on those contacts most likely to be at risk for infection and sets the timeframe for testing contacts. Because the start of the infectious period cannot be determined with precision by available methods, a practical estimation is necessary. On the basis of expert opinion, an assigned start that is 3 months before a TB diagnosis is recommended (Table 2). In certain circumstances, an even earlier start should be used. For example, a patient (or the patient's associates) might have been aware of protracted illness (in extreme cases, >1 year). Information from the patient interview and from other sources should be assembled to assist in estimating the infectious period.

Helpful details are the approximate dates that TB symptoms were noticed, mycobacteriologic results, and extent of disease (especially the presence of large lung cavities, which imply prolonged illness and infectiousness) (40, 41).

Please see the CDPH/CTCA revision of combined CDC Figure 1, CDC Tables 2 and 3 in [Addendum 6](#).

Addendum 8

See LAC DPH TBCP Addendum 9, Establishing an Infectious Period.

The infectious period is closed when the following criteria are satisfied: 1) effective treatment (as demonstrated by *M. tuberculosis* susceptibility results) for ≥ 2 weeks; 2) diminished symptoms; and 3) mycobacteriologic response (e.g., decrease in grade of sputum smear positivity detected on sputum-smear microscopy). The exposure period for individual contacts is determined by how much time they spent with the index patient during the infectious period. Multidrug-resistant TB (MDR TB) can extend infectiousness if the treatment regimen is ineffective. Any index patient with signs of extended infectiousness should be continually reassessed for recent contacts.

CDPH/CTCA recommends that contacts without evidence of LTBI and with ongoing exposure to an infectious TB case (e.g., household contacts) should be reassessed every 8-10 weeks during the infectious period and 8-10 weeks after the infectious period is closed (See p.33 “Post Exposure Tuberculin Skin Testing”)

CDPH/CTCA recognizes that for patients with very lengthy estimated infectious periods (e.g., > 1 year) it may not be feasible to identify all high priority contacts. In this situation, an investigation may be initiated using a shorter estimated infectious period (e.g., 6 months). If there is not strong evidence of TB transmission in this abbreviated infectious period, there is no need to expand the timeframe. If however, there is evidence of transmission throughout the abbreviated infectious period, the original full infectious period should be used.

Addendum 9

LAC DPH TBCP supports CDPH/CTCA Addendum 9 and provides Table below to aid in establishing an infectious period.

LAC DPH TBCP – Establishing an Infectious Period

Patients with sputum smear positive for AFB OR cavitory chest x-ray OR with TB symptoms (e.g. cough, hoarseness)	Patients with sputum smear negative for AFB, AND non-cavitory chest x-ray AND NO TB symptoms
IP Beginning: 3 months prior to symptom onset or 1 st positive finding consistent with TB disease (whichever is longer)	IP Beginning: 4 weeks prior to date of suspected diagnosis (date of treatment started)
IP Ending: All three of the following criteria need to be met: completion and tolerance of 14 days of appropriate TB treatment (preferably via DOT), 3 consecutive negative sputum AFB smears, and clinical improvement. The IP ending date is the latest date out of the 3 criteria.	IP Ending: After at least 5 days of appropriate TB treatment is taken and tolerated.

NOTE: For MDR cases regardless of sputum AFB smear status, cavitation on chest x-ray or TB symptoms the closure of the infectious period will differ. MDR cases will require additional criteria of at least 3 consecutive negative sputum cultures without a subsequent positive culture and 14 days of TB treatment.

More stringent criteria should be applied for setting the end of the infectious period if particularly susceptible contacts are involved. A patient returning to a congregate living setting or to any setting in which susceptible persons might be exposed should have at least three consecutive negative sputum AFB smear results from sputum collected ≥ 8 hours apart (with one specimen collected during the early morning) before being considered noninfectious (42).

CDPH/CTCA guidelines for collection of sputum specimens for assessment of infectiousness, closing the infectious period, and release to high-risk settings can be found at www.ctca.org.

CDPH/CTCA considers 8 hours between sputum specimen collection to be a minimum standard and local health departments (LHDs) may elect to use a longer time interval between collection of sputum specimens.

Addendum 10

LAC DPH TBCP supports CDPH/CTCA Addendum 10

Note: Please refer to 2012 LAC DPH TBCP Discharge and Transfer Guidelines for Tuberculosis Patients and Suspects (<http://publichealth.lacounty.gov/tb/docs/discharge.pdf>)

Interviewing the Patient

In addition to setting the direction for the contact investigation, the first interview provides opportunities for the patient to acquire information regarding TB and its control and for the public health worker to learn how to provide treatment and specific care for the patient. Because of the urgency of finding other infectious persons associated with the index patient, the first interview should be conducted ≤ 1 business day of reporting for infectious persons and ≤ 3 business days for others. The interview should be conducted in person (i.e., face to face) in the hospital, the TB clinic, the patient's home, or a convenient location that accommodates the patient's right to privacy.

A minimum of two interviews is recommended. At the first interview, the index patient is unlikely to be oriented to the contact investigation because of social stresses related to the illness (e.g., fear of disability, death, or rejection by friends and family). The second interview is conducted 1–2 weeks later, when the patient has had time to adjust to the disruptions caused by the illness and has become accustomed to the interviewer, which facilitates a two-way exchange. The number of additional interviews required depends on the amount of information needed and the time required to develop consistent rapport.

Interviewing skills are crucial because the patient might be reluctant to share vital information stemming from concerns regarding disease-associated stigma, embarrassment, or illegal activities. Interviewing skills require training and periodic on-the-job tutoring. Only trained personnel should interview index patients.

In addition to standard procedures for interviewing TB patients (43), the following general principles should be considered:

- **Establishing rapport.** Respect should be demonstrated by assuring privacy during the interview. Establishing respect is critical so rapport can be built. The interviewer should display official identification and explain the reasons for the interview. The interviewer should also discuss confidentiality and privacy (see Confidentiality and Consent in Contact Investigations) in frank terms that help the patient decide how to share information. These topics should be discussed several times during the interview to stress their importance. Sufficient time should be allocated, possibly >1 hour, for a two-way exchange of information, although the patient's endurance should be considered.
- **Information exchange.** The interviewer should confirm information from the preinterview phase, obtain missing information, and resolve disparities. Obtaining information regarding how to locate the patient throughout treatment is crucial. The beginning of the infectious period should be set from the information derived from this exchange.
- **Transmission settings.** Information regarding transmission settings that the patient attended during the infectious period is needed for listing the contacts and assigning priorities (see Investigating the Index Patient and Sites of Transmission). Topics to discuss include where the patient spent nights, met with friends, worked, ate, visited, and sought health care. The interviewer should ask specifically regarding congregate settings (e.g.,

high school, university, correctional facility, homeless shelter, or nursing home). The interviewer also should inquire regarding routine and nonroutine travel. Contacts not previously identified might have been exposed during the patient's infectious period while the patient was traveling. Routine travel modes (e.g., carpool) could also be settings in which contacts were exposed.

- **Sites of transmission.** The key to efficient contact investigations is setting priorities. The investigator must constantly balance available resources, especially staff time, with expected yield. However, the interview with the patient should be as comprehensive as possible. All possible sites of transmission should be listed, regardless of how long the patient spent at the sites. Priorities should be set on the basis of the time spent by the index patient, and decisions regarding investigation of the sites and contacts should be made after all the information has been collected (see Assigning Priorities to Contacts and When to Expand a Contact Investigation).
- **List of contacts.** For each transmission setting, the interviewer should ask for the names of contacts and the approximate types, frequencies, and durations of exposure. Ideal information regarding each contact includes full name, aliases or street names, a physical description, location and communication information (e.g., addresses and telephone numbers), and current general health. The interviewer might need to spend more time asking regarding contacts who are difficult for the patient to remember. Recent illnesses among contacts should be discussed.

CDPH/CTCA recommends identifying information, such as relationship to others (e.g., “my roommate’s friend”) and physical description be collected even if the patient does not know a contact’s name.

Addendum 11

LAC DPH TBCP supports CDPH/CTCA Addendum 11.

- **Closure.** The interviewer should express appreciation, provide an overview of the processes in the contact investigation, and remind the patient regarding confidentiality and its limits. The patient especially should be told how site visits are conducted and confidentiality protected. An appointment for the next interview should be set within the context of the schedule for medical care.
- **Follow-up interviews.** The best setting for the second and subsequent interviews is the patient's residence. If the original interviewer senses incomplete rapport with the index patient, a second interviewer can be assigned. The follow-up interviews are extensions of the initial interview. If the interviewer senses resistance to meeting in certain places or discussing those places, making site visits to those places might facilitate identification of additional contacts whom the index patient had not remembered or wanted to name.

Proxy Interview

Proxy interviews can build on the information provided by the index patient and are essential when the patient cannot be interviewed. Key proxy informants are those likely to know the patient's practices, habits, and behaviors; informants are needed from each sphere of the patient's life (e.g., home, work, and leisure). However, because proxy interviews jeopardize patient confidentiality, TB control programs should establish clear guidelines for these interviews that recognize the challenge of maintaining confidentiality.

CDPH/CTCA believes that proxy interviews, when used routinely, are a valuable tool for clarifying information provided by the patient and identifying additional contacts. When a TB patient is deceased, a proxy interview is essential. Key proxy informants should be asked if organs or tissues were harvested from the deceased patient as the recipients would be at risk for transplant associated TB.

Addendum 12

LAC DPH TB CP supports CDPH/CTCA Addendum 12.

Field Investigation

Site visits are complementary to interviewing. They add contacts to the list and are the most reliable source of information regarding transmission settings (17). Failure to visit all potential sites of transmission has contributed to TB outbreaks (25,44). Visiting the index patient's residence is especially helpful for finding children who are contacts (17,38). The visit should be made <3 days of the initial interview. Each site visit creates opportunities to interview the index patient again, interview and test contacts, collect diagnostic sputum specimens, schedule clinic visits, and provide education. Sometimes environmental clues (e.g., toys suggesting the presence of children) create new directions for an investigation. Certain sites (e.g., congregate settings) require special arrangements to visit (see Contact Investigations in Special Circumstances). Physical conditions at each setting contribute to the likelihood of transmission. Pertinent details include room sizes, ventilation systems, and airflow patterns. These factors should be considered in the context of how often and how long the index patient was in each setting.

CDPH/CTCA recommends that the findings of the interview and field investigation and a plan of action be documented in writing and included in the patient's public health record.

Addendum 13

LAC DPH TBCP supports CDPH/CTCA Addendum 13.

Follow-Up Steps

A continuing investigation is shaped by frequent reassessments of ongoing results (e.g., secondary TB cases and the estimated infection rate for groups of contacts). Notification and follow-up communications with public health officials in other jurisdictions should be arranged for out-of-area contacts.

The following organizations provide resources to make referrals for contacts and index patients who migrate across the U.S.-Mexican border between the United States and Mexico:

- Cure TB (<http://www.curetb.com>), a referral program provided by the County of San Diego for TB patients and their contacts who travel between the United States and Mexico;
- Migrant Clinicians' Network (TB Net) (<http://www.migrantclinician.org/network/tbnet>), a multinational TB patient tracking and referral project designed to work with mobile, underserved populations; and
- Referral System for Binational TB Patients Pilot Project (http://www.borderhealth.org/files/res_329.doc), a collaborative effort between CDC and the National Tuberculosis Program in Mexico to improve continuity of care for TB patients migrating across the border (see Contact Investigations in Special Circumstances).

Updated Resources

CureTB (www.curetb.org) – managed by the County of San Diego Health and Human Services Agency. Makes referrals for high risk contacts (<5 y/o, immunocompromised) and active TB cases moving between the United States and Mexico.

TBNET (<http://www.migrantclinician.org/services/tbnet.html>) – managed by Migrant Clinician's Network. Makes referrals for active TB cases moving to countries other than Mexico and provides tracking services for migrant populations moving within the United States.

These resources may change. Contact your LHD or the CDPH-TBCB for information on available resources.

Addendum 14

LAC DPH TBCP recommends that CHS staff follow the current LAC instructions for International, Interjurisdictional, and Cure TB Notification.

TBCP intranet site

<http://intranet/ph/PHDirector/ChiefDeputyDirector/CommunDiseaseCtrlPrev/TBControl/TB.htm>

TBCP Internet site

'For Health care Professionals-Forms' <http://publichealth.lacounty.gov/tb/healthpro.htm>

Specific Investigation Plan

See Specific Investigation Plan Appendix C (renamed appendix B)

Addendum 15

LAC DPH TBCP supports the use of [Appendix B](#) as a guideline and has provided a reference grid to aid in the completion of major CI Core Team objectives (see Chapter 6, section 3).

The investigation plan starts with information gathered in the interviews and site visits; it includes a registry of the contacts and their assigned priorities (see Assigning Priorities to Contacts and Medical Treatment for Contacts with LTBI). A written timeline (Table 3) sets expectations for monitoring the progress of the investigation and informs public health officials whether additional resources are needed for finding, evaluating, and treating the high- and medium-priority contacts. The plan is a pragmatic work in progress and should be revised if additional information indicates a need (see When to Expand a Contact Investigation); it is part of the permanent record of the overall investigation for later review and program evaluation. Data from the investigation should be recorded on standardized forms (see Data Management and Evaluation of Contact Investigations).

Please see the CDPH/CTCA revision to CDC Figure 1 and CDC Tables 2 and 3 in Addendum 6.

Addendum 16

LAC DPH TBCP Time frames for initial follow-up of contacts of persons exposed to tuberculosis

characteristics of index patient	contact priority	Time frame for follow-up	
TB 3 OR 5		From elicitation of contact to initial screening and testing** (calendar days)	From initial screening and testing to completion of medical evaluation (calendar days)
SPUTUM AFB SMEAR (+) OR CAVITARY CHEST X-RAY OR TB SYMPTOMS	high	5-7	7
	medium	14	10
	low	8-10 weeks after last known exposure	14 days from date of screening
SPUTUM AFB SMEAR (-) AND NON-CAVITARY CHEST X-RAY AND NO TB SYMPTOMS	high	7	10
	medium	14	10
	low	8-10 weeks after last known exposure	14 days from date of screening

*not including repeat testing 8-10 weeks after last exposure

** The time frame for follow-up are for those contacts at sites/settings where the CI Core Team has determined a true exposure has taken place.

Assigning Priorities to Contacts

The ideal goal would be to distinguish all recently infected contacts from those who are not infected and prevent TB disease by treating those with infection. In practice, existing technology and methods cannot achieve this goal. For example, although a relatively brief exposure can lead to *M. tuberculosis* infection and disease (45), certain contacts are not infected even after long periods of intensive exposure. Not all contacts with substantial exposure are identified during the contact investigation. Finally, available tests for *M. tuberculosis* infection lack sensitivity and specificity and do not differentiate between persons recently or remotely infected.

Increasing the intensity and duration of exposure usually increases the likelihood of recent *M. tuberculosis* infection in contacts. The skin test cannot discriminate between recent and old

infections, and including contacts who have had minimal exposure increases the workload while it decreases the public health value of finding positive skin test results. A positive result in contacts with minimal exposure is more likely to be the result of an old infection or nonspecific tuberculin sensitivity (46). Whenever the contact's exposure to the index TB patient has occurred <8–10 weeks necessary for detection of positive skin tests, repeat testing 8–10 weeks after the most recent exposure will help identify recent skin test conversions, which are likely indicative of recent infection.

For optimal efficiency, priorities should be assigned to contacts, and resources should be allocated to complete all investigative steps for high- and medium-priority contacts. Priorities are based on the likelihood of infection and the potential hazards to the individual contact if infected. The priority scheme directs resources to selecting contacts who

- have secondary cases of TB disease,
- have recent *M. tuberculosis* infection and so are most likely to benefit from treatment, and
- are most likely to become ill with TB disease if they are infected (i.e., susceptible contacts) or who could suffer severe morbidity if they have TB disease (i.e., vulnerable contacts).

Factors for Assigning Contact Priorities

Characteristics of the Index Patient

The decision to initiate a contact investigation is determined on the basis of the characteristics of the index patient (see Decisions to Initiate a Contact Investigation). Contacts of a more infectious index patient (e.g., one with AFB sputum smear positive TB) should be assigned a higher priority than those of a less infectious one because contacts of the more infectious patient are more likely to have recent infection or TB disease (19,40,47–50).

Characteristics of Contacts

Intrinsic and acquired conditions of the contact affect the likelihood of TB disease progression after infection, although the predictive value of certain conditions (e.g., being underweight for height) is imprecise as the sole basis for assigning priorities (51,52). The most important factors are age <5 years and immune status. Other medical conditions also might affect the probability of TB disease after infection.

Age. After infection, TB disease is more likely to occur in younger children; the incubation or latency period is briefer; and lethal, invasive forms of the disease are more common (53–58). The age-specific incidence of disease for children who have positive skin test results declines through age 4 years (56). Children aged <5 years who are contacts are assigned high priority for investigation.

A study of 82,269 tuberculin reactors aged 1–18 years who were control subjects in a Bacille Calmette-Guérin (BCG) trial* in Puerto Rico indicated that peak incidence of TB occurred among children aged 1–4 years (56). Infants and postpubertal adolescents are at increased risk for progression to TB disease if infected, and children aged <4 years are at increased risk for disseminated disease (57). The American Academy of Pediatrics also recommends primary

prophylaxis for children aged <4 years (57). Guidelines published by ATS and CDC recommend primary prophylaxis for children aged <5 years (6,59). These guidelines are consistent with previous CDC recommendations in setting the cut-off at age <5 years for assigning priority and recommending primary prophylaxis (6,59).

Immune status. HIV infection results in the progression of *M. tuberculosis* infection to TB disease more frequently and more rapidly than any other known factor, with disease rates estimated at 35–162 per 1,000 person-years of observation and a greater likelihood of disseminated and extrapulmonary disease (60–64). HIV-infected contacts are assigned high priority, and, starting at the time of the initial encounter, extra vigilance for TB disease is recommended.

Contacts receiving >15 mg of prednisone or its equivalent for >4 weeks also should be assigned high priority (6). Other immunosuppressive agents, including multiple cancer chemotherapy agents, antirejection drugs for organ transplantation, and tumor necrosis factor alpha (TNF- α) antagonists, increase the likelihood of TB disease after infection; these contacts also are assigned a high priority (65).

Other medical conditions. Being underweight for their height has been reported as a weakly predictive factor promoting progression to TB disease (66); however, assessing weight is not a practical approach for assigning priorities. Other medical conditions that can be considered in assigning priorities include silicosis, diabetes mellitus, and status after gastrectomy or jejunioileal bypass surgery (67–76).

See CDPH/CTCA Addendum 19 for a list of other medical conditions which increase the risk for TB.

Addendum 17

See LAC DPH TBCP Table 2a and 2b (replacing Addendum 19).

Exposure. Air volume, exhaust rate, and circulation predict the likelihood of transmission in an enclosed space. In large indoor settings, because of diffusion and local circulation patterns, the degree of proximity between contacts and the index patient can influence the likelihood of transmission. Other subtle environmental factors (e.g., humidity and light) are impractical to incorporate into decision making. The terms "close" and "casual," which are frequently used to describe exposures and contacts, have not been defined uniformly and therefore are not useful for these guidelines.

The most practical system for grading exposure settings is to categorize them by size (e.g., "1" being the size of a vehicle or car, "2" the size of a bedroom, "3" the size of a house, and "4" a

size larger than a house [16]). This has the added advantage of familiarity for the index patient and contacts, which enables them to provide clearer information.

The volume of air shared between an infectious TB patient and contacts dilutes the infectious particles, although this relationship has not been validated entirely by epidemiologic results (15, 77–79). Local circulation and overall room ventilation also dilute infectious particles, but both factors can redirect exposure into spaces that were not visited by the index patient (80–83). These factors have to be considered.

The likelihood of infection depends on the intensity, frequency, and duration of exposure (16, 17, 40, 84). For example, airline passengers who are seated for ≥ 8 hours in the same or adjoining row as a person who is contagious are much more likely to be infected than other passengers (85–88). One set of criteria for estimating risk after exposure to a person with pulmonary TB without lung cavities includes a cut-off of 120 hours of exposure per month (84). However, for any specific setting, index patient, and contacts, the optimal cut-off duration is undetermined. Administratively determined durations derived from local experience are recommended, with frequent reassessments on the basis of results.

Classification of Contacts

CDPH/CTCA has developed an amended framework for prioritizing contacts, Addendum 19.

Addendum 18

LAC DPH TBCP See Table 2a and 2b (replacing Addendum 19).

Priorities for contact investigation are determined on the basis of the characteristics of the index patient, susceptibility and vulnerability of contacts, and circumstances of the exposures (Figures 2–4).

Any contacts who are not classified as high or medium priority are assigned a low priority. Because priority assignments are practical approximations derived from imperfect information, priority classifications should be reconsidered throughout the investigation as findings are analyzed (see When to Expand a Contact Investigation).

LAC DPH TBCP –Addendum 19 is replaced with LAC specific Tables 2a and 2b.

Table 2a: Exposure to a TB 3 or TB 5 case of pulmonary, laryngeal, and/or pleuro-pulmonary TB with

- **Positive sputum AFB smear or**
- **Cavitary lesion on chest radiograph**

High Priority Contacts	Medium Priority Contacts	Low Priority Contacts
<ol style="list-style-type: none"> 1. Children under 5 years of age 2. Immunosuppressed contacts: <ol style="list-style-type: none"> a. Infected with HIV b. Immunosuppressive medical treatment, for example: <ul style="list-style-type: none"> - \geq 15mg day of prednisone or its equivalent for one month or more - Cancer chemotherapy agents - Antirejection drugs for organ transplantation - Tumor necrosis factor alpha (TNF-α) antagonists (e.g. for autoimmune diseases like rheumatoid arthritis, Crohn’s disease) 3. Other conditions that increase risk of progression from latent TB infection to active disease once infected: <ol style="list-style-type: none"> a. Chronic kidney disease / end-stage renal failure b. Diabetes mellitus c. Silicosis d. Head or neck cancer e. Hematological and reticuloendothelial disease (e.g. leukemias and lymphomas) f. Intestinal bypass or gastrectomy g. Chronic malabsorption syndrome h. Low body weight (>10% below ideal body weight) i. Chronic alcoholism j. Increased risk for HIV infection (including intravenous drug-use) 4. Exposure during an aerosol-inducing medical procedure (e.g. autopsy, bronchoscopy or sputum induction) 5. Significant exposure based on intensity <u>AND</u> \geq8 hours of exposure during any one week of the infectious period* 	<ol style="list-style-type: none"> 1. Persons five years and older, not already classified as high priority with significant exposure based on intensity <u>OR</u> \geq8 hours of exposure during any one week of the infectious period* 2. Any contact who does not meet the above criteria but deemed to be medium priority by the CI Core Team 	<p>Any contacts, who are not already classified as high or medium priority, and who have limited exposure to the index case</p>

*Examples of intense exposure include: Carpooling with the index case several times a week, sharing the same house or living space as the index case, and sharing air with the index case in small, enclosed spaces with little natural ventilation or mechanical ventilation with re-circulated air

Table 2b. Exposure to a TB 3 or TB 5 case of pulmonary, laryngeal and/or pleuro-pulmonary TB with:

- ***Negative sputum AFB smear, and***
- ***Abnormal, non-cavitary chest radiography consistent with TB disease***
- ***Started on TB treatment***

High Priority Contacts	Medium Priority Contacts	Low Priority Contacts
<p>1. Children under 5 years of age</p> <p>2. Immunosuppressed contacts:</p> <p>a. Infected with HIV</p> <p>b. Immunosuppressive medical treatment, for example:</p> <ul style="list-style-type: none"> - ≥ 15mg day of prednisone or its equivalent for one month or more - Cancer chemotherapy agents - Antirejection drugs for organ transplantation - Tumor necrosis factor alpha (TNF-α) antagonists (e.g. for autoimmune diseases like rheumatoid arthritis, Crohn's disease) <p>3. Other conditions that increase risk of progression from latent TB infection to active disease once infected:</p> <p>a. Chronic kidney disease / end-stage renal failure</p> <p>b. Diabetes mellitus</p> <p>c. Silicosis</p> <p>d. Head or neck cancer</p> <p>e. Hematological and reticuloendothelial disease (e.g. leukemias and lymphomas)</p> <p>f. Intestinal bypass or gastrectomy</p> <p>g. Chronic malabsorption syndrome</p> <p>h. Low body weight (>10% below ideal body weight)</p> <p>i. Chronic alcoholism</p> <p>j. Increased risk for HIV infection (including intravenous drug-use)</p> <p>4. Exposure during an aerosol-inducing medical procedure (e.g. autopsy, bronchoscopy or sputum induction)</p>	<p>1. Persons five years and older, not already classified as high priority with significant exposure based on intensity</p> <p style="text-align: center;"><u>AND</u></p> <p>≥ 8 hours of exposure during any one week of the infectious period*</p> <p>2. Any contact who does not meet the above criteria but deemed to be medium priority by the CI Core Team</p>	<p>Any contacts, who are not already classified as high or medium priority, and who have limited exposure to the index case</p>

* Examples of intense exposure include: Carpooling with the index case several times a week, sharing the same house or living space as the index case and sharing air with the index case in small, enclosed spaces with little natural ventilation or mechanical ventilation with re-circulated air

Diagnostic and Public Health Evaluation of Contacts

On average, 10 contacts are listed for each person with a case of infectious TB in the United States (50,59,89). Approximately 20%–30% of all contacts have LTBI, and 1% have TB disease (50). Of those contacts who ultimately will have TB disease, approximately half acquire disease in the first year after exposure (90,91). For this reason, contact investigations constitute a crucial prevention strategy.

Identifying TB disease and LTBI efficiently during an investigation requires identifying, locating, and evaluating high- and medium-priority contacts who are most at risk. Because they have legally mandated responsibilities for disease control, health departments should establish systems for comprehensive TB contact investigations. In certain jurisdictions, legal measures are in place to ensure that evaluation and follow-up of contacts occur. The use of existing communicable disease laws that protect the health of the community (if applicable to contacts) should be considered for contacts who decline examinations, with the least restrictive measures applied first.

CDPH/CTCA recommends that each jurisdiction should have a policy on steps taken to locate and complete evaluation of contacts. Disposition of contacts should depend on the infectiousness of the source case and the risk level of the contact. An example of a policy is available at www.ctca.org under the “Guidelines” section. Efforts to locate contacts should be documented in writing.

If there is a concern that a contact has active TB and is non-compliant with medical evaluation, the Health Officer or TB Controller may consider issuing legal orders for examination (see *California Health and Safety Code* §121363, §121364, §121365 and §120175 and *California Code of Regulations Title 17, Section 2501*). Information about legal orders can be found at www.ctca.org/legal/index.html. If parents or guardians do not comply with recommendations for medical examination for a minor contact, consider referral to Child Protective Services.

Addendum 20

LAC DPH TB CP – Recommends that CHS staff continue with current LAC practice in locating contacts, completing evaluation, and following up on Broken Appointment (BA). LAC specific information for contacts that break appointments can be found in LAC TB Control Manual Chapter 6.

Initial Assessment of Contacts

See CDPH/CTCA Addendum 6 for guidelines on the timeframe for contact evaluation.

Addendum 21

LAC DPH TBCP see [LAC DPH TBCP addendum 16, Time Frames for Initial Follow-up of Contacts.](#)

During the initial contact encounter, which should be accomplished within 3 working days of the contact having been listed the investigation, the investigator gathers background health information and makes a face-to-face assessment of the person's health. Administering a skin test at this time accelerates the diagnostic evaluation.

The health department record should include:

- previous *M. tuberculosis* infection or disease and related treatment;
- contact's verbal report and documentation of previous TST results;
- current symptoms of TB illness (e.g., cough, chest pain, hemoptysis, fever, chills, night sweats, appetite loss, weight loss, malaise, or easy fatigability);
- medical conditions or risk factors making TB disease more likely (e.g., HIV infection, intravenous drug use, diabetes mellitus, silicosis, prolonged corticosteroid therapy, other immunosuppressive therapy, head or neck cancer, hematological and reticuloendothelial diseases, end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, or low body weight);
- mental health disorders (e.g., psychiatric illnesses and substance abuse disorders);
- type, duration, and intensity of TB exposure; and
- sociodemographic factors (e.g., age, race or ethnicity, residence, and country of birth) (see Data Management and Evaluation of Contact Investigations).

Contacts who do not know their HIV-infection status should be offered HIV counseling and testing. Each contact should be interviewed regarding social, emotional, and practical matters that might hinder their participation (e.g., work or travel).

When initial information has been collected, priority assignments should be reassessed for each contact, and a medical plan for diagnostic tests and possible treatment can be formulated for high- and medium-priority contacts. Low-priority contacts should not be included unless resources permit and the program is meeting its performance goals.

In 2002, for the first time, the percentage of TB patients who were born outside the United States was >50%; this proportion continues to increase (92). Because immigrants are likely to settle in communities in which persons of similar origin reside, multiple contacts of foreign-born index patients also are foreign born. Contacts who come from countries where both BCG

vaccination and TB are common are more likely than other immigrants to have positive skin tests results when they arrive in the United States. They also are more likely to demonstrate the booster phenomenon on a postexposure test (17, 40). Although valuable in preventing severe forms of disease in young children in countries where TB is endemic, BCG vaccination provides imperfect protection and causes tuberculin sensitivity in certain recipients for a variable period of time (93, 94). TSTs cannot distinguish reactions related to remote infection or BCG vaccination from those caused by recent infection with *M. tuberculosis*; boosting related to BCG or remote infection compounds the interpretation of positive results (95).

A positive TST in a foreign-born or BCG-vaccinated person should be interpreted as evidence of recent *M. tuberculosis* infection in contacts of persons with infectious cases. These contacts should be evaluated for TB disease and offered a course of treatment for LTBI.

The CDPH-TBCB Patient Locating Service can assist with locating high priority contacts if accurate contact information is not available. Information about the Patient Locating Service is located at <http://www.cdph.ca.gov/programs/tb/Documents/TBCB-PLS-Patient-Locating-Services-09-07.pdf>

Addendum 22

LAC DPH TBCP recommends that CHS staff continue with the current LAC practice in locating contacts. All efforts to locate a contact at the local level should be exhausted then refer/consult TBCP PHI. If further assistance is needed then TBCP will contact the CDPH-TBCB Patient Locating Service.

Voluntary HIV Counseling, Testing, and Referral

Approximately 9% of TB patients in the United States have HIV infection at the time of TB diagnosis, with 16% of TB patients aged 25–44 years having HIV infection (96). In addition, an estimated 275,000 persons in the United States are unaware they have HIV infection (97). The majority of TB contacts have not been tested for HIV infection (98). Contacts of HIV-infected index TB patients are more likely to be HIV infected than contacts of HIV-negative patients (99).

Voluntary HIV counseling, testing, and referral for contacts are key steps in providing optimal care, especially in relation to TB (100, 101). Systems for achieving convenient HIV-related services require collaboration with health department HIV-AIDS programs. This also can improve adherence to national guidance for these activities (100).

CDPH/CTCA recommends HIV testing for all TB cases and suspects (“Guidelines for the Treatment of Active Tuberculosis Disease”) as well as for all high priority contacts and individuals who identify risk behaviors for HIV regardless of contact priority status. Please consult with your health department for local HIV testing protocols.

Addendum 23

LAC DPH TBCP supports CDPH/CTCA Addendum 23.

For the CDPH/CTCA position on the use of IGRAs in contact investigations, please see http://www.ctca.org/guidelines/CTCA_QFT_Position_Statement.pdf. Additional information is provided on p.-- (section: Use of Blood Tests for Detection of Latent M. tuberculosis Infection).

Addendum 24

Above reference is no longer available, the CDPH/CTCA Interferon Gamma Release Assays Clinical Guidelines in California can be found at http://www.ctca.org/fileLibrary/file_374.pdf

Tuberculin Skin Testing

All contacts classified as having high or medium priority who do not have a documented previous positive TST result or previous TB disease should receive a skin test at the initial encounter.

If that is not possible, then the test should be administered ≤ 7 working days of listing high-priority contacts and ≤ 14 days of listing medium-priority contacts. For interpreting the skin test reaction, an induration transverse diameter of ≥ 5 mm is positive for any contact (1)

CDPH/CTCA recommends different timeframes for initial follow-up of contacts of persons exposed to TB. Detailed CDPH/CTCA recommendations can be found in Addendum 6.

Addendum 25

LAC DPH TBCP see [LAC DPH TBCP addendum 16, Time Frames for Initial Follow-up of Contacts.](#)

Serial tuberculin testing programs routinely administer a two-step test at entry into the program. This detects boosting of sensitivity and can avoid misclassifying future positive results as new infections. The two-step procedure typically should not be used for testing contacts; a contact whose second test result is positive after an initial negative result should be classified as recently infected.

Postexposure Tuberculin Skin Testing

Among persons who have been sensitized by *M. tuberculosis* infection, the intradermal tuberculin from the skin test can result in a delayed-type (cellular) hypersensitivity reaction. Depending on the source of recommendations, the estimated interval between infection and detectable skin test reactivity (referred to as the window period) is 2–12 weeks (6,95). However, reinterpretation of data collected previously indicates that 8 weeks is the outer limit of this window period (46,102–106). Consequently, NTCA and CDC recommend that the window period be decreased to 8–10 weeks after exposure ends. A negative test result obtained <8 weeks after exposure is considered unreliable for excluding infection, and a follow-up test at the end of the window period is therefore recommended.

Low-priority contacts have had limited exposure to the index patient and a low probability of recent infection; a positive result from a second skin test among these contacts would more likely represent boosting of sensitivity. A single skin test, probably at the end of the window period, is preferred for these contacts. However, diagnostic evaluation of any contact who has TB symptoms should be immediate, regardless of skin test results.

Nonspecific or remote delayed-type hypersensitivity (DTH) response to tuberculin (PPD in the skin test) occasionally wanes or disappears over time. Subsequent TSTs can restore responsiveness; this is called boosting or the booster phenomenon (95,107). For contacts who receive two skin tests, the booster phenomenon can be misinterpreted as evidence of recent infection. This misinterpretation is more likely to occur for foreign-born contacts than it is for those born in the United States (17,108).

Skin test conversion refers to a change from a negative to a positive result. To increase the relative certainty that the person has been infected with *M. tuberculosis* in the interval between tests, the standard U.S. definition for conversion includes a maximum time (2 years) between skin tests and a minimum increase (10 mm) in reaction size (6,34). With the 5 mm cut-off size used for interpreting any single skin test result obtained in contact investigations, the standard definition for conversion typically is irrelevant. For these guidelines, contacts who have a positive result after a previous negative result are said to have had a change in tuberculin status from negative to positive.

CDPH/CTCA recommends that expert consultation be obtained in interpreting TST results in a contact investigation if there is uncertainty about whether individuals have had clinically significant TST changes. A variety of factors such as degree of exposure, risk of progression to active TB, and TST history should be considered in determining whether an individual contact should be considered a converter or to have had a change in tuberculin status.

Addendum 26

LAC DPH TBCP supports CDPH/CTCA Addendum 26. The table below is provided to aid in the definition of TST conversion in a contact investigation. CHS staff may consult with LAC DPH TBCP as necessary.

scenario	Previous TST status	First post-exposure TST result	Repeat post-exposure TST result	TST converter?
1	No previous documented TST	<5 mm	Increase of at least 5 mm	Yes
		≥ 5 mm	Do not place TST	No (Reactor)
2	Documented previous TST within last 2 years was < 5 mm	<5 mm	Increase of at least 5 mm	Yes
		≥ 5 mm	Do not place TST	Yes
3	Documented previous TST within last 2 years was qualitatively “negative” but no quantitative measurement was noted	< 5 mm	Increase of at least 5 mm	Yes
		≥ 5 mm	Do not place	Yes

⁺Any person with a documented TST negative greater than 2 years prior to exposure who tests positive on the first post-exposure TST (≥5mm) is considered a reactor and not a converter.

Medical Evaluation

All contacts whose skin test reaction induration diameter is ≥5 mm or who report any symptoms consistent with TB disease should undergo further examination and diagnostic testing for TB (6), starting typically with a chest radiograph. Collection of specimens for mycobacteriologic testing (e.g., sputa) is decided on a case-by-case basis and is not recommended for healthy contacts with normal chest radiographs. All contacts who are assigned a high priority because of special susceptibility or vulnerability to TB disease should undergo further examination and diagnostic testing regardless of whether they have a positive skin test result or are ill.

Evaluation and Follow-Up of Specific Groups of Contacts

Because children aged <5 years are more susceptible to TB disease and more vulnerable to invasive, fatal forms of TB disease, they are assigned a high priority as contacts and should

receive a full diagnostic medical evaluation, including a chest radiograph ([Figure 2](#)). If an initial skin test induration diameter is ≤ 5 mm and the interval since last exposure is < 8 weeks, treatment for presumptive *M. tuberculosis* infection (i.e., window prophylaxis) is recommended after TB disease has been excluded by medical examination. After a second skin test administered 8–10 weeks postexposure, the decision to treat is reconsidered. If the second test result is negative, treatment should be discontinued and the child, if healthy, should be discharged from medical supervision. If the second result is positive, the full course of treatment for latent *M. tuberculosis* infection should be completed.

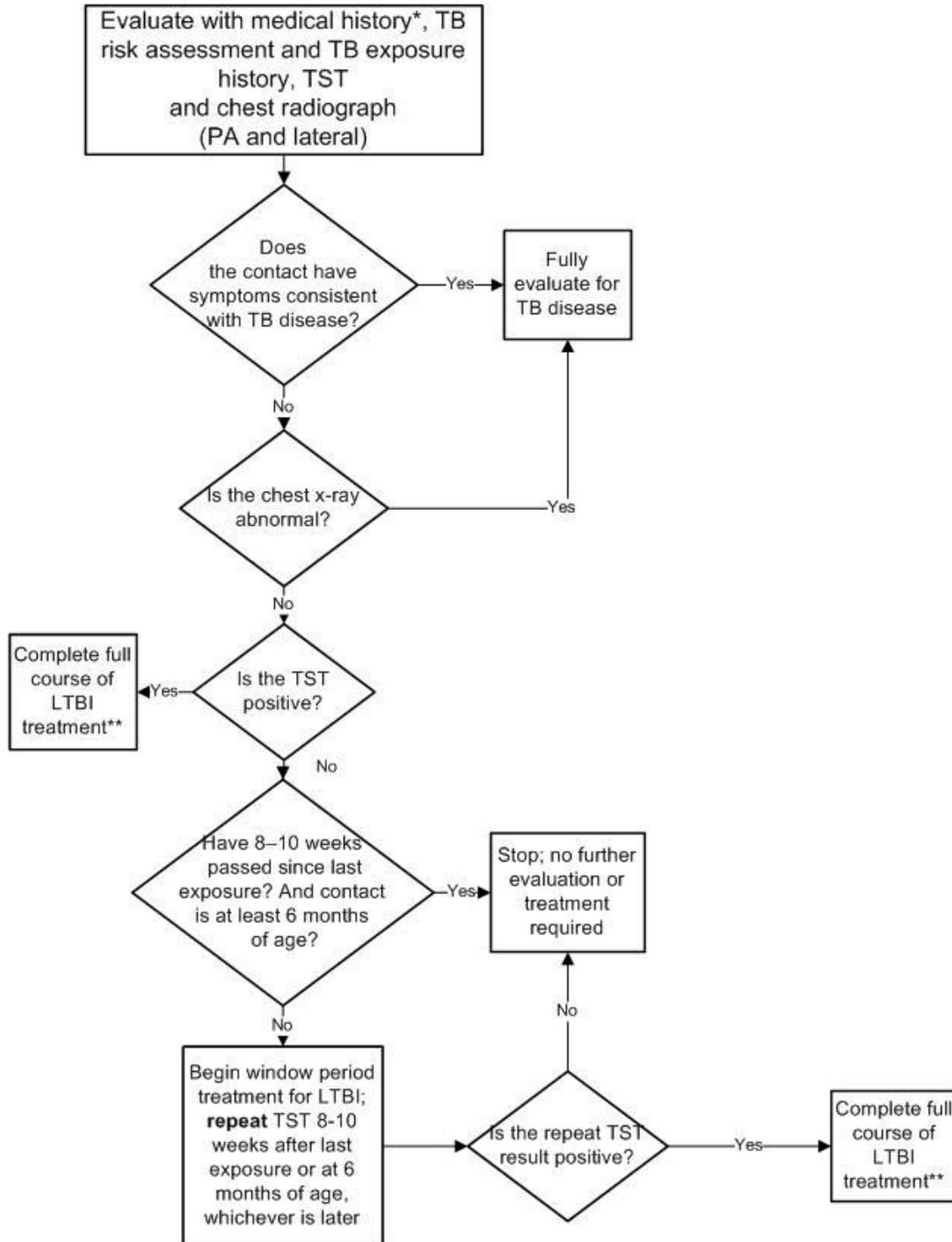
Chest radiography for children less than 5 years of age should include PA and lateral views. Because the TST may not be reliable in children under 6 months of age, CDPH/CTCA guidelines (“Targeted Testing and Treatment of Latent Tuberculosis in Adults and Children” (5/06)

http://www.ctca.org/fileLibrary/file_61.pdf recommend continuation of window prophylaxis and repeat TST after 6 months of age. The decision to stop or continue treatment should be based on the TST done after the child is 6 months of age. Nevertheless, an initial TST should be placed, regardless of the patient’s age. While a negative test in a child less than 6 months of age may be a false negative, a positive test is reliable and useful for management of the child and evaluation of transmission.

Addendum 27

LAC DPH TBCP supports CDPH/CTCA Addendum 27.

Figure 2 Diagnosis and Evaluation of Contacts
Evaluation, treatment, and follow-up of contacts aged <5 years

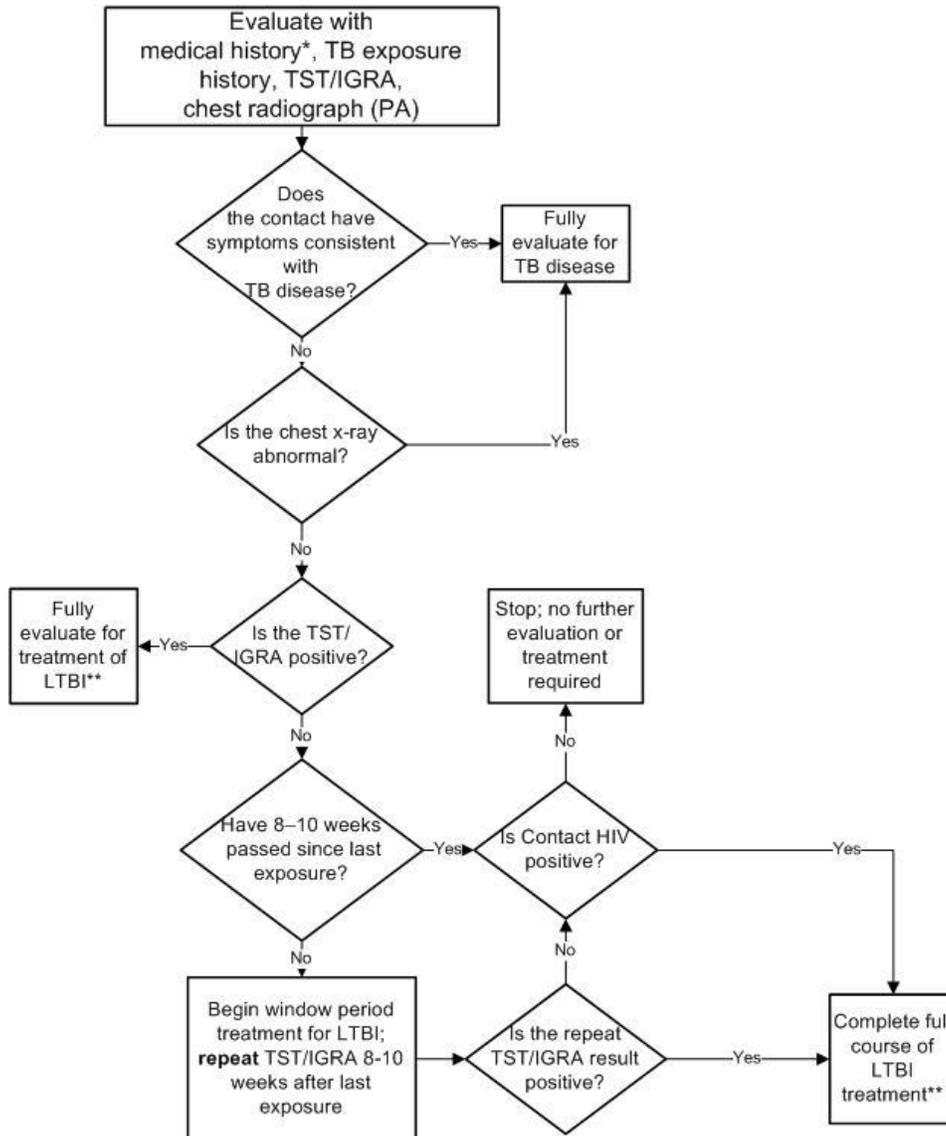


* A medical history should include an assessment of TB risk factors, including comorbid conditions that predispose the contact to an increase risk of progression to TB disease if infected. High and medium priority contacts who have not had an HIV test in the past year should be offered HIV testing as a routine part of their evaluation.

**Special attention should be paid to immunosuppressed contacts to ensure that they do not have TB disease when starting therapy for LTBI. Careful physician evaluation should precede any decision to initiate LTBI treatment in an immunosuppressed contact.

Contacts with immunocompromising conditions (e.g., HIV infection) should receive similar care ([Figure 3](#)). In addition, even if a TST administered >8 weeks after the end of exposure yields a negative result, a full course of treatment for latent *M. tuberculosis* infection is recommended after a medical evaluation to exclude TB disease (16). The decision to administer complete treatment can be modified by other evidence concerning the extent of transmission that was estimated from the contact investigation data.

Figure 3 Diagnosis and Evaluation of Contacts
Evaluation, treatment, and follow-up of immunosuppressed^ contacts ≥5 years old



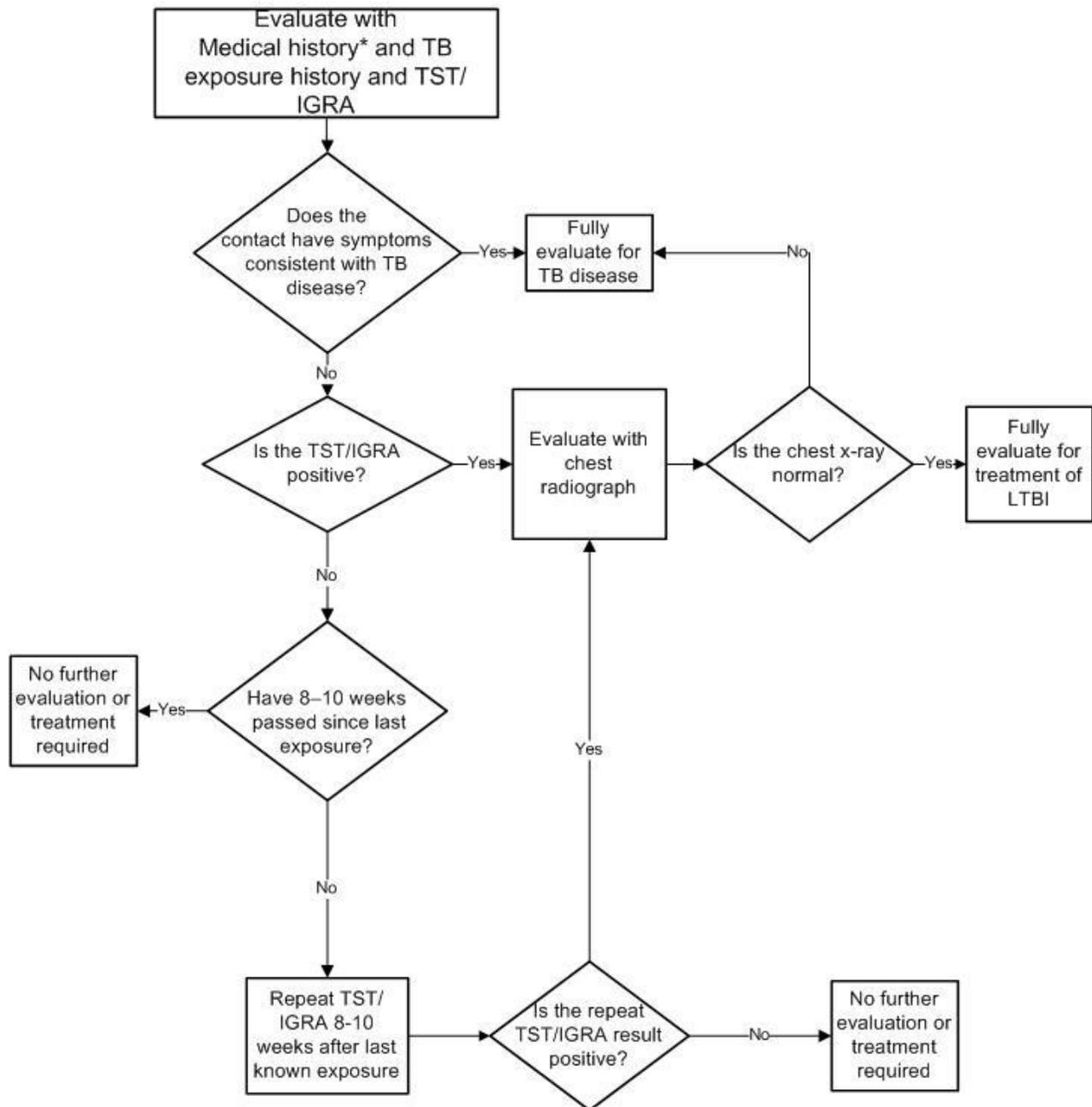
^See tables 2a and 2b, #2 for description of immunosuppressed contacts

* A medical history should include an assessment of TB risk factors, including comorbid conditions that predispose the contact to an increase risk of progression to TB disease if infected. High and medium priority contacts who have not had an HIV test in the past year should be offered HIV testing as a routine part of their evaluation.

**Special attention should be paid to immunosuppressed contacts to ensure that they do not have TB disease when starting therapy for LTBI. Careful physician evaluation should precede any decision to initiate LTBI treatment in an immunosuppressed contact

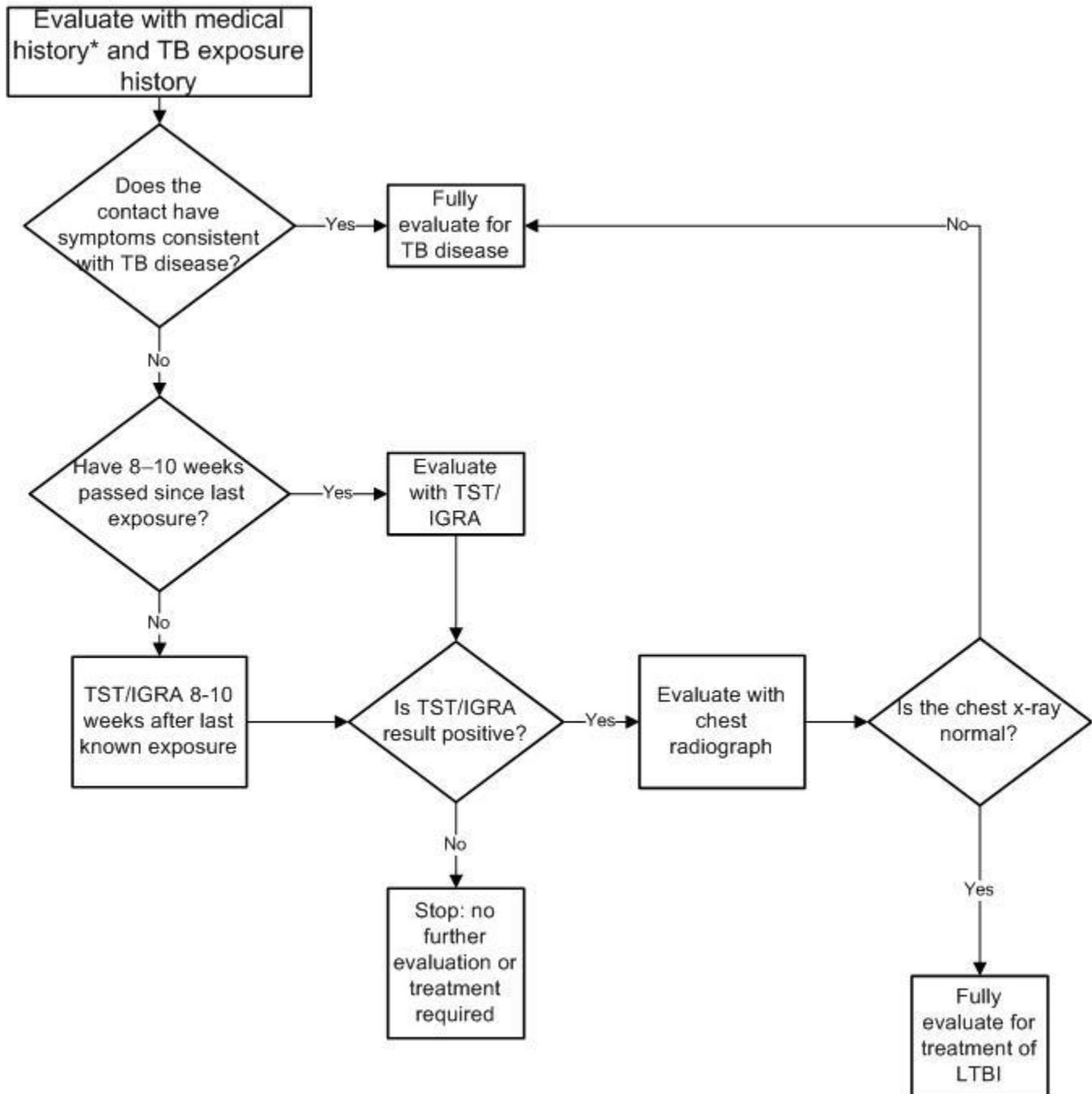
The majority of other high- or medium priority contacts who are immunocompetent adults or children aged >5 years can be tested and evaluated as described (Figure 4). Treatment is recommended for contacts who receive a diagnosis of latent *M. tuberculosis* infection.

Figure 4 Diagnosis and Evaluation of Contacts
Evaluation, treatment, and follow-up of high and medium priority contacts, that are not immunosuppressed and children aged ≥ 5 years



* A medical history should include an assessment of TB risk factors, including comorbid conditions that predispose the contact to an increase risk of progression to TB disease if infected. High and medium priority contacts who have not had an HIV test in the past year should be offered HIV testing as a routine part of their evaluation.

Figure 5 Diagnosis and Evaluation of Contacts
Evaluation, treatment, and follow-up of low-priority contacts



* A medical history should include an assessment of TB risk factors, including comorbid conditions that predispose the contact to an increase risk of progression to TB disease if infected. High and medium priority contacts who have not had an HIV test in the past year should be offered HIV testing as a routine part of their evaluation.

Addendum 31

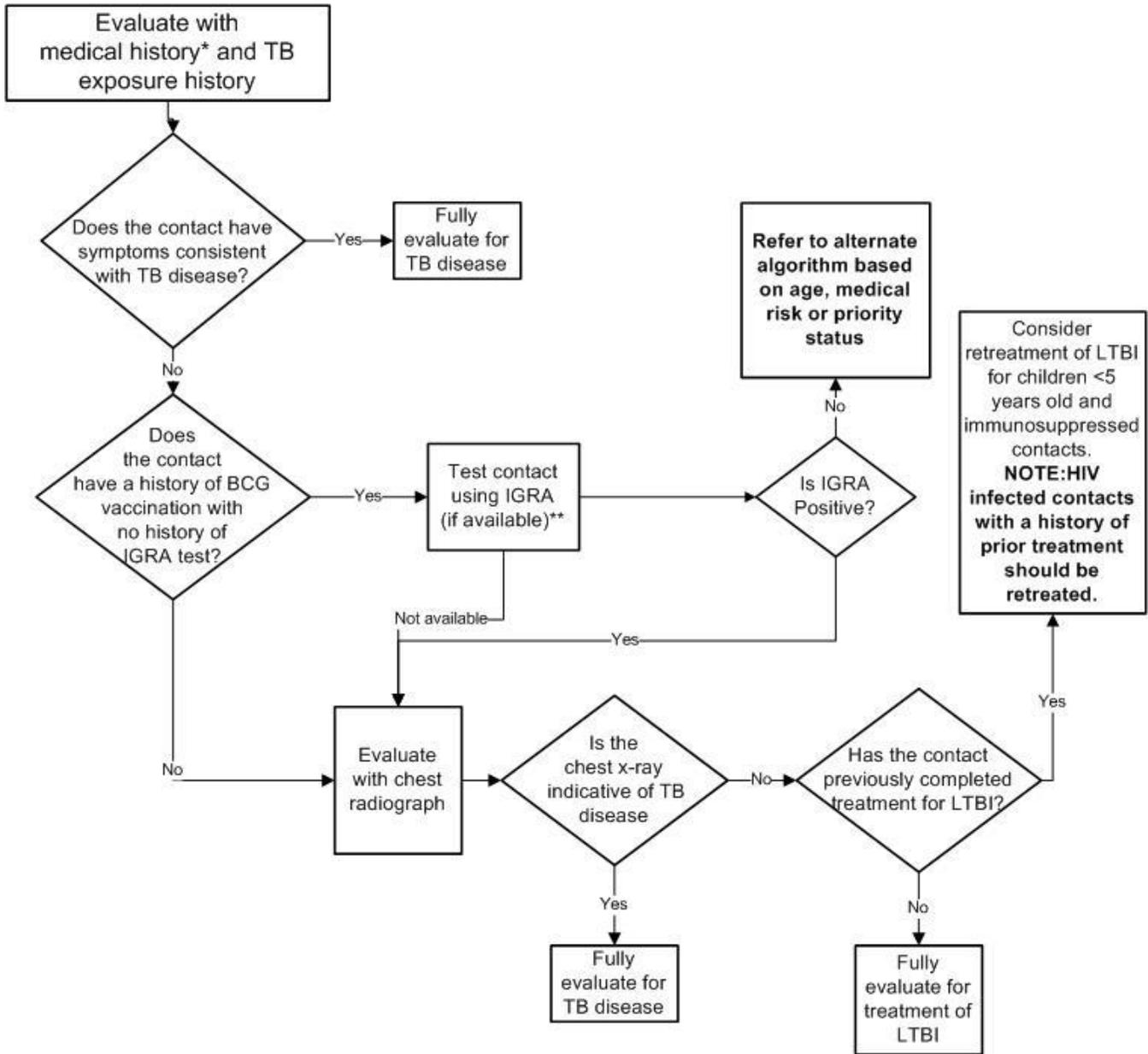
Evaluation of low-priority contacts who are being tested can be scheduled with more flexibility ([Figure 5](#)). The skin test may be delayed until after the window period, thereby negating the

need for a second test. Treatment is also recommended for these contacts if they receive a diagnosis of latent *M. tuberculosis* infection.

The risk for TB disease is undetermined for contacts with documentation of a previous positive TST result (whether infection was treated) or TB disease ([Figure 6](#)). Documentation is recommended before making decisions from a contact's verbal report. Contacts who report a history of infection or disease but who do not have documentation are recommended for the standard algorithm ([Figure 5](#)). Contacts who are immunocompromised or otherwise susceptible are recommended for diagnostic testing to exclude TB disease and for a full course of treatment for latent *M. tuberculosis* infection after TB disease has been excluded, regardless of their previous TB history and documentation. Healthy contacts who have a documented previous positive skin test result but have not been treated for LTBI can be considered for treatment as part of the contact investigation. Any contact who is to be treated for LTBI should have a chest radiograph to exclude TB disease before starting treatment.

Figure 6 Diagnosis and Evaluation of Contacts

Evaluation, treatment, and follow-up of contacts with a documented previously positive tuberculin skin test or IGRA



* A medical history should include an assessment of TB risk factors, including comorbid conditions that predispose the contact to an increase risk of progression to TB disease if infected. High and medium priority contacts who have not had an HIV test in the past year should be offered HIV testing as a routine part of their evaluation.

**If available, testing with an IGRA would be most useful in patients that have been previously BCG vaccinated.

Addendum 32

Certain guidance regarding collecting historic information from TB patients or contacts stipulates confirmation of previous TST results (e.g., a documented result from a TST) (4). The decision regarding requiring documentation for a specific detail involves a subtle balance. Memory regarding medical history might be weak or distorted, even among medically trained persons. However, the accuracy of details reported by a TB patient or contact might not be

relevant for providing medical care or collecting data. For previous TST results, patients can be confused regarding details from their history; routine skin tests sometimes are administered at the same time as vaccinations, and foreign-born patients might confuse a skin test with BCG vaccination or streptomycin injections. For contacts (but not patients with confirmed TB), a skin test result is critical, and documentation of a previous positive result should be obtained before omitting the skin test from the diagnostic evaluation.

Treatment for Contacts with LTBI

The direct benefits of contact investigations include 1) finding additional TB disease cases (thus potentially interrupting further transmission) and 2) finding and treating persons with LTBI. One of the national health objectives for 2010 (objective no. 14-13) is to complete treatment in 85% of contacts who have LTBI (107). However, reported rates of treatment initiation and completion have fallen short of national objectives (17,50,109,110). To increase these rates, health department TB control programs must invest in systems for increasing the numbers of infected contacts who are completely treated. These include 1) focusing resources on the contacts most in need of treatment; 2) monitoring treatment, including that of contacts who receive care outside the health department; and 3) providing directly observed therapy (DOT), incentives, and enablers.

Contacts identified as having a positive TST result are regarded as recently infected with *M. tuberculosis*, which puts them at heightened risk for TB disease (6,7). Moreover, contacts with greater durations or intensities of exposure are more likely both to be infected and to have TB disease if infected. A focus first on high-priority and next on medium-priority contacts is recommended in allocating resources for starting and completing treatment of contacts.

Decisions to treat contacts who have documentation of a previous positive skin test result or TB disease for presumed LTBI must be individualized because their risk for TB disease is unknown. Considerations for the decision include previous treatment for LTBI, medical conditions putting the contact at risk for TB disease, and the duration and intensity of exposure.

CDPH/CTCA recommends considering evidence of transmission and the age of the contact (<5 years) when treating patients with a prior positive TB test.

Addendum 33

LAC DPH TBEP supports CDPH/CTCA Addendum 33.

Treatment of presumed LTBI is recommended for all HIV-infected contacts in this situation (after TB disease has been excluded), whether they received treatment previously.

CDPH/CTCA acknowledges that for contacts evaluated and/or managed by non-LHD providers, LHDs are still responsible for ensuring that evaluation is completed, addressing barriers to care, and monitoring contact disposition, including treatment completion. See CDPH/CTCA guidelines for Oversight of Tuberculosis Care Provided Outside the Local Health Department Tuberculosis Program (4/97).

http://www.ctca.org/fileLibrary/file_209.pdf

Addendum 34

LAC DPH TBCP supports CDPH/CTCA Addendum 34.

Window-Period Prophylaxis

Treatment during the window period (see Diagnostic and Public Health Evaluation of Contacts) has been recommended for susceptible and vulnerable contacts to prevent rapidly emerging TB disease (4,6,56,61,111). The evidence for this practice is inferential, but all models and theories support it. Groups of contacts who are likely to benefit from a full course of treatment (beyond just window-period treatment) include those with HIV infection, those taking immunosuppressive therapy for organ transplantation, and persons taking TNF- α antagonists (6,61,62,65). The risks for TB are less clear for patients who chronically take the equivalent of >15 mg per day of prednisone (6). TB disease having been ruled out, prophylactic treatment of presumed *M. tuberculosis* infection is recommended as an option for all these groups. The decision as to whether to treat individual contacts who have negative skin test results should take into consideration two factors:

- the frequency, duration, and intensity of exposure (even brief exposure to a highly contagious TB patient in a confined space probably warrants the same concern as extended exposure to less contagious patients); and
- corroborative evidence of transmission from the index patient (a substantial fraction of contacts having positive skin test results implies contagiousness).

Treatment after Exposure to Drug-Resistant TB

Guidelines for providing care to contacts of drug-resistant TB patients and selecting treatment regimens have been published (6, 7,112). Drug susceptibility results for the *M. tuberculosis* isolate from the index patient (i.e., the presumed source of infection) are necessary for selecting or modifying the treatment regimen for the exposed contact. Resistance only to INH among the first line agents leaves the option of 4 months of daily rifampin. Additional resistance to rifampin constitutes MDR TB. None of the potential regimens for persons likely infected with MDR TB has been tested fully for efficacy, and these regimens are often poorly tolerated. For these reasons, consultation with a physician with expertise in this area is recommended for selecting or modifying a regimen and managing the care of contacts (6).

Contacts who have received a diagnosis of infection attributed to MDR TB should be monitored for 2 years after exposure; guidelines for monitoring these contacts have been published previously (6).

Curry International TB Center has developed a resource for the management of multi drug-resistant TB. *Drug-Resistant Tuberculosis: A Survival Guide for Clinicians*, Second Edition (2008) <http://www.nationaltbcenter.edu/drtb/>. According to this document, contacts of MDR cases should be treated with DOPT if local resources permit, especially those at high risk for progression and non-adherence.

Addendum 35

LACDPH/TBC requires that CHS staff contact and consult with LAC TBCP MDR Unit for expert consultation on every suspect or case of MDR/XDR TB.

Adherence to Treatment

One of the national health objectives for 2010 is to achieve a treatment completion rate of 85% for infected contacts who start treatment (objective no. 14-13) (107). However, operational studies indicate that this objective is not being achieved (17,110). Although DOT improves completion rates (17), it is a resource-intensive intervention that might not be feasible for all infected contacts. The following order of priorities is recommended when selecting contacts for DOT (including window-period prophylaxis):

- contacts aged <5 years,
- contacts who are HIV infected or otherwise substantially immunocompromised,
- contacts with a change in their tuberculin status from negative to positive, and
- contacts who might not complete treatment because of social or behavior impediments (e.g., alcohol addiction, chronic mental illness, injection-drug use, unstable housing, or unemployment).

Checking monthly or more often for adherence and adverse effects of treatment by home visits, pill counts, or clinic appointments is recommended for contacts taking self-supervised treatment. All contacts being treated for infection should be evaluated in person by a health-care provider at least monthly. Incentives (e.g., food coupons or toys for children) and enablers (e.g., transportation vouchers to go to the clinic or pharmacy) are recommended as aids to adherence. Incentives provide simple rewards whereas enablers increase a patient's opportunities for adherence. Education regarding TB, its treatment, and the signs of adverse drug effects should be part of each patient encounter.

When to Expand a Contact Investigation

A graduated approach to contact investigations (i.e., a concentric circles model) has been recommended previously (4, 5, 113). With this model, if data indicate that contacts with the greatest exposure have an infection rate greater than would be expected in their community, contacts with progressively less exposure are sought. The contact investigation would expand until the rate of positive skin test results for the contacts was indistinguishable from the prevalence of positive results in the community (5). In addition to its simplicity and intuitive appeal, an advantage to this approach is that contacts with less exposure are not sought until evidence of transmission exists. Disadvantages are that 1) surrogates for estimating exposure (e.g., living in the same household) often do not predict the chance of infection, 2) the susceptibility and vulnerability of contacts are not accommodated by the model, and 3) the estimated prevalence for tuberculin sensitivity in a specific community generally is unknown. In addition, when the prevalence for a community is known but is substantial (e.g., >10%), the end-point for the investigation is obscured.

Recent operational studies indicate that health departments are not meeting their objectives for high- and medium-priority contacts (17, 50, 109). In these settings, contact investigations generally should not be expanded beyond high- and medium-priority contacts. However, if data from an investigation indicate more transmission than anticipated, more contacts might need to be included.

When determining whether to expand the contact investigation, consideration of the following factors is recommended:

- achievement of program objectives with high- and medium-priority contacts; and
- extent of recent transmission, as evidenced by
 - unexpectedly high rate of infection or TB disease in high-priority contacts (e.g., 10% or at least twice the rate of a similar population without recent exposure, whichever is greater),
 - evidence of secondary transmission (i.e., from TB patients who were infected after exposure to the source patient),
 - TB disease in any contacts who had been assigned a low priority,
 - infection of contacts aged <5 years, and
 - contacts with change in skin test status from negative to positive between their first and second TST.

In the absence of evidence of recent transmission, an investigation should not be expanded to lower priority contacts. When program-evaluation objectives are not being achieved, a contact investigation should be expanded only in exceptional circumstances, generally those involving highly infectious persons with high rates of infection among contacts or evidence for secondary cases and secondary transmission. Expanded investigations must be accompanied by efforts to ensure completion of therapy.

The strategy for expanding an investigation should be derived from the data obtained from the investigation previously (4, 5, 43). The threshold for including a specific contact thereby is decreased. As in the initial investigation, results should be reviewed at least weekly so the strategy can be reassessed.

At times, results from an investigation indicate a need for expansion that available resources do not permit. In these situations, seeking consultation and assistance from the next higher level in public health administration (e.g., the county health department consults with the state health department) is recommended. Consultation offers an objective review of strategy and results, additional expertise, and a potential opportunity to obtain personnel or funds for meeting unmet needs.

CDPH/CTCA recognizes that not all TST conversions represent definitive evidence of recent transmission (see Post Exposure Tuberculin Skin Testing, p. 33). Some contacts who appear to be TST converters on repeat testing could represent persons who had boosted TST reactions. For this reason, consultation with an expert with experience in interpreting TST results is often helpful when considering expanding a contact investigation solely on the basis of a high conversion rate.

Addendum 36

LAC DPH TBC supports CDPH/CTCA Addendum 36 and has provided a table in addendum 26 to aid in the definition of TST conversion in a contact investigation.

Communicating Through the Media

Routine contact investigations, which have perhaps a dozen contacts, are not usually considered newsworthy. However, certain contact investigations have potential for sensational coverage and attract attention from the media. Typical examples include situations involving numerous contacts (especially children), occurring in public settings (e.g., schools, hospitals, prisons), occurring in workplaces, associated with TB fatalities, or associated with drug-resistant TB.

Reasons for Participating in Media Coverage

Media coverage can provide both advantages and drawbacks for the health department, and careful planning is recommended before communicating with reporters. Favorable, accurate coverage

- educates the public regarding the nature of TB,
- reminds the public of the continued presence of TB in the community,
- provides a complementary method to alert exposed contacts of the need for seeking a medical evaluation,

- relieves unfounded public fears regarding TB,
- illustrates the health department's leadership in communicable disease control,
- ensures that constructive public inquiries are directed to the health department, and
- validates the need for public resources to be directed to disease control.

Potential drawbacks of media coverage are that such coverage can

- increase public anxiety, especially after alarmist or inaccurate messages,
- lead unexposed persons seeking unnecessary health care because of a perceived threat,
- contribute to unfavorable views of the health department (e.g., because of perceived delays in responding to the TB problem),
- contribute to spread of misinformation regarding the nature of TB,
- trigger unconstructive public inquiries, and
- lead to disclosure of confidential information (e.g., patient identity).

Strategy for Media Coverage

Anticipatory preparation of clear media messages, coordinated among all parties for clarity and consistency, is recommended. The majority of health departments have formal policies and systems for arranging media communications, and TB control officials are advised to work with their media-communications services in securing training and preparing media messages anticipating news coverage. In certain instances, this will require coordination among local, state, and federal public health organizations. Issuing a press release in advance of any other media coverage is recommended so as to provide clear, accurate messages from the start. Waiting until a story reaches the media through other sources leaves the health department reacting to inaccuracies in the story and could lend credence to a perception that information is being withheld from the public.

Certain newsworthy contact investigations involve collaborators outside of the health department because of the setting (e.g., a homeless shelter). The administrators of these settings are likely to have concerns, distinct from the public health agenda, regarding media coverage. For example, a hospital administrator might worry that reports of suspected TB exposures in the hospital will create public distrust of the hospital. Collaboration on media messages is a difficult but necessary part of the overall partnership between the hospital (in this example) and the health department. Early discussions regarding media coverage are recommended for reducing later misunderstandings. In addition, development of a list of communication objectives also is recommended in preparing for media inquiries.

CDPH/CTCA suggests referring to the Health Officer Practice Guide for Communicable Disease Control in California, “Media Resources and Management” section (January 2007) for operational guidance and to ensure consistency between the TB program and Health Officer practices.

<http://www.cdph.ca.gov/programs/dcdc/Documents/Health-Officer-Practice-Guide-DCDC.pdf>

CDPH/CTCA recommends the following information should be included in a clear, concise message when communicating through the media:

- Appropriate information about the case while maintaining confidentiality
- Potential exposure including location and/or community needing to be screened for TB infection
- Basic facts about TB including local epidemiology, transmission, infection, and treatment of latent and active disease. Whenever possible, tailor this information to the community impacted by the investigation (e.g. children, racial/ethnic group, drug resistant index case, etc.)
- TB is not a public health emergency and is a preventable and curable disease
- The health department’s role in the investigation and current actions taken to halt transmission, identify and evaluate contacts and ensure resources are available for the investigation
- Contact information for the health department and other informational resources available

Tuberculosis control programs in California may contact the CDPH-TBCB or CPCA for media tools and templates.

Addendum 37

LAC DPH TBCP - Refer to LAC DPH Policy No. 400 Contact with News Media.

CHS and LAC DPH TBCP may consult with LAC DPH External Communications & Relations for any correspondence sent to employers, groups of contacts, legal guardians/parents of contacts, etc. This is especially recommended in complex contact investigations.

Data Management and Evaluation of Contact Investigations

Data collection related to contact investigations has three broad purposes: 1) management of care and follow-up for individual index patients and contacts, 2) epidemiologic analysis of an investigation in progress and investigations overall, and 3) program evaluation using

performance indicators that reflect performance objectives. A systematic, consistent approach to data collection, organization, analysis, and dissemination is required (114–117).

Data collection and storage entail both substantial work and an investment in systems to obtain full benefits from the efforts. Selecting data for inclusion requires balancing the extra work of collecting data against the lost information if data are not collected. If data are collected but not studied and used when decisions are made, then data collection is a wasted effort. The most efficient strategy for determining which data to collect is to work back from the intended uses of the data.

Reasons Contact Investigation Data Are Needed

For each index patient and the patient's associated contacts, a broad amount of demographic, epidemiologic, historic, and medical information is needed for providing comprehensive care (Tables 2, 4, and 5). In certain instances, such care can last >1 year, so information builds by steps and has numerous longitudinal elements (e.g., number of clinic visits attended, number of treatment doses administered, or mycobacteriologic response to treatment). Data on certain process steps are necessary for monitoring whether the contact investigation is keeping to timeline objectives (e.g., how soon after listing the skin test is administered to a contact).

TABLE 4 Minimal recommended data concerning the index patient

Identifiers and demographic information

Case manager
Name and aliases
For minors and dependents, guardian information
Date of birth*
Social security number
Current locating information and emergency contacts
Residences during infectious period if unstably housed
RVCT number* and local case number
Sex*
Race*
Ethnicity*
Country of birth*
If foreign born length of time in United States*
Primary language and preferred language
Methods of translation or interpretation

Settings in which index patient might have transmitted tuberculosis (TB) and associated timeframes

Living situation(s)
Employment or school
Social and recreational activities
Congregate settings (e.g. jail or homeless shelter)*
Substance abuse with social implications (e.g., crack cocaine)*

TB information

Health-care provider for TB (e.g., public health, private, both, other)*
Anatomic site of disease*
Symptoms and their dates
Chest radiograph results, including presence of cavity*
TB medications with start and stop dates*
Bacteriologic results (sputum smear, culture, and drug susceptibility) with dates*
Previous history of TB disease and treatment*
Previous history of exposure to other persons diagnosed with TB
Infectious period (updated as new information arrives)
HIV infection status*
HARS[†] number

Contact investigation

Date of initial interview with index patient
Dates of follow-up interviews with the index patient

*Data items collected on the Report of a Verified Case of Tuberculosis (RVCT) form.

[†]HIV/AIDS Reporting System.

Table 5. Minimal data recommended concerning each contact of persons with tuberculosis

Investigator and dates

- Contact manager or investigator
- Date listed
- How or why contact was listed (e.g., named by index patient)
- Dates of interviews
- Start and end dates for exposure (updated as new information arrives)

Identifiers

- Name and aliases
- For minors and dependents, guardian information
- Social security number
- Date of birth
- Locating information and emergency contacts
- Sex
- Race
- Ethnicity
- Country of birth
- If foreign born, length of time in the United States
- Primary language and preferred language
- Methods of translation or interpretation

Relationship or connection to index patient

Social affiliations (e.g., work, school, church, clubs, or activities)

Environmental information about exposure settings (e.g., size or ventilation)

CDPH/CTCA suggests that the following categories are useful for characterizing the exposure environment:

Size: *approximately the size of a car, bedroom, house, larger than a house.*

Ventilation: *closed windows/no ventilation, air conditioning/central ventilation, open windows, completely open to outside outdoors*

Addendum 38

LAC DPH TBCP supports CDPH/CTCA Addendum 38 and has provided a Exposure Site Assessment Worksheet within Chapter 6 of the TB Manual to aid in the investigation of sites and settings.

Frequency, duration, and time frame of interactions

Previous history of TB disease or latent infection, and documentation

BCG[†] vaccination and date

Medical risk factors for progression of infection to TB disease

Population risk factors for prevalent *M. tuberculosis* infection*

Evaluation for TB disease and latent infection

Health-care provider for TB (e.g., public health, private, both, or other)

Symptoms suggesting TB disease

Tuberculin skin tests, with dates, reagents, and lot numbers, and reaction measurement

Chest radiograph results with dates

Bacteriologic results with dates

HIV infection status

Final diagnostic classifications for latent *M. tuberculosis* infection or disease

Treatment information for contacts with latent *M. tuberculosis* infection

Dates of treatment

Treatment regimen (medication, dosing schedule, and any changes to these)

Methods of supervising treatment (e.g., directly observed treatment.)

Adverse effects (specify each)

Interruptions in regimen and dates

Outcome of treatment (e.g., completion, consistent with ARPE *)

If treatment not completed, reason*

* Aggregate report for program evaluation,

[†]Bacille Calmette-Guerin

Aggregated data collected during an investigation inform public health officials whether the investigation is on time and complete. The ongoing analysis of data also contributes to reassessment of the strategy used in the investigation (e.g., whether the infection rate was greater for contacts believed to have more exposure).

Data from a completed investigation and from all investigations in a fixed period (e.g., 6 months) might demonstrate progress in meeting program objectives ([addendum 39](#)). However, these core measurements for program evaluation cannot directly demonstrate why particular objectives were not achieved. If the data are structured and stored in formats that permit detailed retrospective review, then the reasons for problems can be studied. CDC's Framework for Program Evaluation in Public Health is recommended for assessing the overall activities of contact investigations ([118](#)).

CDPH/CTCA Box 2 footnote:

California sets state specific objectives for these indicators. Current California objectives can be found at <http://www.cdph.ca.gov/programs/tb/Documents/TBCB-TIP-CaliforniaObjectives.doc>

Addendum 39

LAC DPH TBCP sets National TB Program objectives for these indicators. Current National TB Program Objectives can be found at <http://www.cdc.gov/tb/programs/Evaluation/Indicators/ProgramObjectives.pdf>

Recommended objectives for contact investigations, by key national indicators (NTIP)

Key indicator	Objectives
Infectious index patients with at least one contact listed	100%
Contacts who are evaluated for tuberculosis disease and latent infection	93%
Infected contacts who begin treatment for latent infection	88%
Treated contacts who complete treatment for latent infection	79%

Data definitions are crucial for consistency and subsequent mutual comprehension of analytic results. However, detailed definitions that accommodate every contingency defeat the simplicity required for an efficient system. Data definitions are best when they satisfy the most important contingencies. This requires a trade-off between completeness and clarity. As with the initial selection of data, working back from the intended uses of the data is helpful in deciding how much detail the data definitions should have.

Routine data collection can indicate whether the priority assignments of contacts were a good match to the final results (e.g., infection rates and achievement of timelines). These data cannot determine whether all contacts with substantial exposure were included in the original list (i.e., whether certain contacts who should have been ranked as high priority were missed completely because of gaps in the investigation).

Methods for Data Collection and Storage

Examples of data collection instruments, including case information forms, contact rosters, and contact information forms can be found at <http://www.cdph.ca.gov/programs/tb/Pages/TBSurvFormsTBCB.aspx>

Addendum 40

LAC DPH TBCP specific forms can be found in the LAC TB Control Manual
http://intranet/ph/PDFs/PolicyProcedures/TBControl/TB_Manual.pdf

Direct computer entry of all contact investigation data is recommended. Systems designed to increase data quality (e.g., through use of error checking rules) are preferred. However, technologic and resource limitations are likely to require at least partial use of paper forms and subsequent transfer at a computer console, which requires a greater level of data quality assurance because of potential errors in the transfer. Security precautions for both paper copy and electronically generated data should be commensurate with the confidentiality of the information. Ongoing training concerning systems is recommended for personnel who collect or use the data.

A comprehensive U.S. software system for contact investigation data collection and storage has not been implemented. Health department officials are advised to borrow working systems from other jurisdictions that have similar TB control programs. Any system should incorporate these recommendations.

Computer storage of data offers improved performance of daily activities because a comprehensive system can provide reminders regarding the care needs of individual contacts (e.g., notification regarding contacts who need second skin tests and recommended dates). A system also can perform interim analysis of aggregate results at prescheduled intervals. This contributes both to reassessment of the investigative strategy (see *When to Expand a Contact Investigation*) and to program evaluation.

Confidentiality and Consent in Contact Investigations

Multiple laws and regulations protect the privacy and confidentiality of patients' health care information (119). Applicable federal laws include Sections 306 and 308(d) of the Public Health Service Act; the Freedom of Information Act of 1966; the Privacy Act of 1974, which restricts the use of Social Security numbers; the Privacy Protection Act of 1998; and the Privacy Rule of HIPAA, which protects individually identifiable health information and requires an authorization of disclosure (39). Section 164.512 of HIPAA lists exemptions to the need to obtain

authorization, which include communicable diseases reported by a public health authority as authorized by law (120). Interrelationships between Federal and State codes are complex, and consultation with health department legal counsel is recommended when preparing policies governing contact investigations.

Maintaining confidentiality is challenging during contact investigations because of the social connections between an index patient and contacts. Constant attention is required to maintain confidentiality. Ongoing discussions with the index patient and contacts regarding confidentiality are helpful in finding solutions, and individual preferences often can be accommodated. Legal and ethical issues in sharing confidential information sometimes can be resolved by obtaining consent from the patient to disclose information to specified persons and by documenting this consent with a signed form.

The index patient might not know the names of contacts, and contacts might not know the index patient by name. With the patient's consent, a photograph of the patient or of contacts might be a legal option to assist in identifying contacts. In certain places, separate consent forms are required for taking the photograph and for sharing it with other persons. In congregate settings, access to occupancy rosters might be necessary to identify exposed contacts in need of evaluation.

In their approach to confidentiality and consent issues for contact investigations, TB control programs will need to address the following:

- **Policies and training.** Policies explicitly regarding TB contact investigations are recommended for inclusion in the health department's overall policies for protecting confidentiality and breaking it when needed. Consultation with legal counsel improves the utility and validity of the policies. Periodic training in the policies is recommended for all staff who participate in contact investigations, including receptionists, interpreters, and clerical personnel.

CDPH/CTCA suggests training include opportunities for staff to role play commonly encountered situations that can challenge their ability to protect patient confidentiality (e.g., when contacts demand to know who exposed them to TB, or when DOT workers are confronted with inquisitive neighbors).

Addendum 41

LAC DPH/TBCP supports CDPH/CTCA Addendum 41

- **Informed consent.** Consent for disclosure of information in the patient's primary language is recommended. Refusal to grant consent can threaten public health and requires documentation and sometimes legal consultation for determining acceptable interventions. Any deliberate breach of confidentiality by the health department should be authorized by law and documented. Accidental breaches should be brought to the

attention of the legal counsel for advice on remediation. Obtaining informed consent presents the opportunity for learning patient preference for confidentiality. Frequent discussions between health department workers and patients regarding confidentiality can allay mistrust.

CDPH/CTCA recognizes that there may be situations where a minor may need to be interviewed alone, without parent/guardian consent. LHDs should know the position of their County Counsel regarding consent for verbal interviews of minors.

Addendum 42

LAC DPH TBCP – Refer to LAC DPH Policy 321 ‘Providing Care to Minors in the Absence of Parent or Guardian’

(<http://intranet/ph/PDFs/PolicyProcedures/PublicHealth/300/321.pdf>). If questions arise regarding investigations with minors, contact LAC DPH TBCP.

- **Site investigations.** Especially in congregate settings (e.g., the workplace), maintaining confidentiality during a TB contact investigation is threatened by site visits. Anticipatory discussions with the patient can lead to solutions for safeguarding confidentiality, and a patient's preferences should be honored when consistent with laws and good practices (121). In addition, to the extent that onsite administrators already know confidential information regarding an index patient or contacts, they can be asked to respect confidentiality even if they are not legally bound to do so. Employee and occupancy rosters are often shared with health department personnel to facilitate identification of contacts who should be evaluated. Confidentiality of these records also must be safeguarded.
- **Other medical conditions besides TB.** Legal and ethical concerns for privacy and confidentiality extend beyond TB. All personal information regarding an index patient and contacts is afforded the same protections.

Additional information about California laws and regulations can be found in the “Confidentiality of Health Information” section from the Health Officer Practice Guide for Communicable Disease Control in California. (January 2007)

<http://www.cdph.ca.gov/programs/dcdc/Documents/Health-Officer-Practice-Guide-DCDC.pdf>

Addendum 43

LAC DPH TBCP supports Addendum 43 Refer to LAC DPH Policy No. 320 Informed Consent (<http://intranet/ph/PDFs/PolicyProcedures/PublicHealth/300/320.pdf>).

Staffing and Training for Contact Investigations

The multiple interrelated tasks in a contact investigation require personnel in the health department and other health-care-delivery systems to fulfill multiple functions and skills (Box 3). Training and continuous on-the-job supervision in all these functions help ensure successful contact investigations.

CDPH/CTCA acknowledges training and oversight is important for successful interviewing and contact investigation. Training and oversight related to cultural competence should be provided. Numerous training resources are available through TB-Education Training Network, the CDC's online TB training database: <http://www.findtbresources.org/scripts/index.cfm>. See p. 84 for additional information on cultural competency.

Addendum 44

LAC DPH TBCP – Information on ‘cultural competency related to TB care’ can be found at:

Regional Training and Medical Consultation Centers' TB Training and Education Products Search ‘cultural’ <http://sntc.medicine.ufl.edu/RTMCCProducts.aspx>

CDC Ethnographic Guides: Promoting Cultural Sensitivity – A Practical Guide for Tuberculosis Programs

<http://www.cdc.gov/tb/publications/guidestoolkits/EthnographicGuides/default.htm>

BOX 2. Specialized functions for contact investigations

Interviewing
Data collection and management
Epidemiologic analysis
Medical record review
Tuberculin skin testing
Exposure environment assessment
Case management
Media relations and public education
Patient education
Medical evaluation and assessment
Medication procurement and management
Program evaluation
Site visits
Patient reception
Protocol development
Social assessment
Investigation coordination

SOURCES: CDC. Essential components of tuberculosis prevention and control program. MMWR 1995;44(No. RR-11): 1-17; CDC. Core curriculum on tuberculosis: what the clinician should know. 4th ed Atlanta, GA: US Department of Health and Human Services, CDC; 2000.

Job titles of personnel who conduct contact investigations vary among jurisdictions (Box 4). State licensing boards and other authorities govern the scope of practice of health department personnel, and this narrows the assignment of functions. Reflection of these licensure-governed functions is recommended for personnel position descriptions, with specific references to contact investigations as duties.

BOX 3. Positions and titles used in contact investigation literature

Tuberculosis (TB) program manger
DOT (directly observed therapy) worker
Case manager
Nurse epidemiologist
Public health nurse (PHN)
Public information/media relations officer
Disease investigation specialist
Physician (health department/hospital or private)
Contact investigation worker
TB medical consultant
Medical epidemiologist
HIV counselor
Outreach worker
Department of Health:
 Investigator
 TB control manger
 Contact investigation interviewer
Regional nurse consultant
Community health worker
Licensed practical nurse
Assessment unit epidemiologist
Public health team
Local health jurisdiction:
 Field staff
 Health officer
 Public health worker
 TB control/public health nurse
 Nursing supervisor
 Manager
 Medical interpreter

SOURCE: CDC. Core curriculum on tuberculosis: what the clinician should know. 4th ed. Atlanta, GA: US Department of Health and Human Services, CDC; 2000.

Contact Investigations in Special Circumstances

Contact investigations frequently involve multiple special circumstances, but these circumstances typically are not of substantive concern. This section lists special challenges and suggests how the general guidance in other sections of this document can be adapted in response.

Outbreaks

A TB outbreak indicates potential extensive transmission. An outbreak implies that 1) a TB patient was contagious, 2) contacts were exposed for a substantial period, and 3) the interval since exposure has been sufficient for infection to progress to disease. An outbreak investigation involves several overlapping contact investigations, with a surge in the need for public health resources. More emphasis on active case finding is recommended, which can result in more contacts than usual having chest radiographs and specimen collection for mycobacteriologic assessment.

Definitions for TB outbreaks are relative to the local context. Outbreak cases can be distinguished from other cases only when certain association in time, location, patient characteristics, or *M. tuberculosis* attributes (e.g., drug resistance or genotype) become apparent. In low-incidence jurisdictions, any temporal cluster is suspicious for an outbreak. In places where cases are more common, clusters can be obscured by the baseline incidence until suspicion is triggered by a noticeable increase, a sentinel event (e.g., pediatric cases), or genotypically related *M. tuberculosis* isolates.

On average in the United States, 1% of contacts (priority status not specified) have TB disease at the time that they are evaluated (50). This disease prevalence is >100 times greater than that predicted for the United States overall. Nonetheless, this 1% average rate is not helpful in defining outbreaks, because substantial numbers of contacts are required for a statistically meaningful comparison to the 1% average.

A working definition of "outbreak" is recommended for planning investigations. A recommended definition is a situation that is consistent with either of two sets of criteria:

- during (and because of) a contact investigation, two or more contacts are identified as having active TB, regardless of their assigned priority; or
- any two or more cases occurring ≤ 1 year of each other are discovered to be linked, and the linkage is established outside of a contact investigation (e.g., two patients who received a diagnosis of TB outside of a contact investigation are found to work in the same office, and only one or neither of the persons was listed as a contact to the other).

The CDPH-TBCB has developed the following outbreak reporting criteria and information on how to report outbreaks. In general, an outbreak is defined as the occurrence of cases above the expected number, usually over a given period of time in a geographic area, facility, or within a specific population group.

When assessing whether a cluster of TB cases represents an outbreak, indicators to look for include:

- Epidemiological links between cases
- Similar characteristics among cases
- Matching drug resistance patterns of isolates
- Matching DNA fingerprint patterns of isolates

Multidrug-resistant TB outbreaks and outbreaks among immunocompromised populations, children, or other vulnerable groups are of special concern.

California law mandates the immediate reporting of outbreaks by telephone to local county health departments, and subsequent reporting from the local health officer to the California Department of Public Health (CDPH) within one week of the outbreak's recognition (California Code of Regulations, Title 17, Sections 2500 and 2502). When an outbreak is initially identified, it should be reported to the TB Control Branch by phone. Call (510) 620-3000 and ask to speak with the TB Outbreak Duty Officer.

The suggested trigger for reporting suspected or confirmed outbreaks to CDPH is when the LHD identifies 3 or more cases with epidemiologic links. However, the characteristics of the case and/or setting may lower the threshold of the number of cases. For example, jurisdictions may want to report 2 epidemiologically or genotypically-linked cases involving multiple households, high risk populations (e.g., persons with HIV infection, children < 5 years of age, or persons with chronic medical conditions associated with elevated risk of TB), MDR TB, or congregate settings. Jurisdictions are welcome to report a situation even if it is not clear whether it is an outbreak, or a situation for which State assistance may be useful.

Note: For all situations, if genotype available, cases with > 1 different spoligotype or MIRU loci should not be counted in the number of cases noted above. Please do not delay reporting while awaiting genotype results.

Definition of epidemiologic link: For the purpose of the above operational outbreak definition, please include both known (known contact or exposure in common) and possible (shared demographic features, geographic locations, and/or social interactions) epidemiologic links.

Addendum 45

LAC DPH TBCP supports CDPH/CTCA Addendum 45. LAC DPH TBCP defines an outbreak as a group of TB cases with epidemiologic links consistent with recent transmission (and matching genotype results, if available). CHS staff should report an outbreak or suspected outbreak to LAC DPH TBCP. Reporting of suspected outbreaks should NOT be delayed while awaiting genotype results.

The linkage between cases should be confirmed by genotyping results if isolates have been obtained (122). Any secondary case that is unexpectedly linked to a known index patient represents a potential failure of certain contact investigation, and therefore the strategy for the original investigation should be reassessed to determine whether the strategy for finding contacts was optimal and whether the priorities were valid or if additional contacts must be sought. If a secondary case occurred because treatment for a known contact with LTBI was not started or completed, then the strategies for treatment and completion should be reviewed.

An outbreak increases the urgency of investigations and places greater demands on the health department. Therefore, whenever possible, a suspected linkage between cases should be corroborated by genotyping results before intensifying an investigation. Even if genotypes match, an epidemiologic investigation is required for determining probable transmission linkages (122–125).

In an outbreak, contacts can be exposed to more than one case, and cases and contacts can be interrelated through multiple social connections which complicate efforts to set priorities. Social network analysis offers an alternative framework (see Other Topics) (126). The risk factors contributing to a specific outbreak should be determined, because these findings will affect the investigation and inform the strategy.

Contagious TB undiagnosed or untreated for an extended period, or an extremely contagious case. The challenges created by the extended infectious period include the patient's inability to remember persons and places and a greater number of contacts in a greater number of places. Social network techniques (see other topics) and setting-based investigations are proxy methods for finding contacts. A highly contagious case, sometimes with several pulmonary cavities or laryngeal disease, suggests a greater number of high-priority contacts. If an outbreak has been discovered, and if the patient has one of these forms of TB, any contacts who have indeterminate exposure data should be classified as high priority.

Sometimes a delay in treating TB is caused by failure to suspect TB or to report it. Opportunities for educating the providers should be pursued immediately, especially if contacts are likely to seek health care from the same providers.

Multidrug resistance can cause prolonged contagiousness if a standard treatment regimen for drug susceptible TB is being administered. This problem can be prevented by obtaining initial susceptibility results, by monitoring the patient's condition and response to therapy, and by suspecting MDR TB when the patient has treatment failure, relapse, or slow recovery from illness (127).

CDPH/CTCA recommends that all patients at increased risk for MDR-TB have rapid identification for drug resistance if available. Persons at increased risk include those with previous treatment for TB, those exposed to known MDR-TB cases, those coming from countries or settings (e.g., certain refugee settings) with a high prevalence of MDR-TB, and those who have a poor response to a standard 4 drug regimen.

Addendum 46

LACDPH/TBCP supports CDPH/CTCA Addendum 46 and also recommends that pyrosequencing (CDPH MDL) or Molecular Detection of Drug Resistance (MDDR) service (CDC).be promptly utilized in any patient at increase risk for MDR TB.

Source patient visiting multiple sites. A TB patient who has an active, complex social life and who frequents multiple sites where transmission of *M. tuberculosis* could occur is also less likely to be able to name all contacts. Proxy interviews (see Investigating the Index Patient and Sites of Transmission) and setting-based investigations are methods that supplement the patient's recall.

Patient and contacts in close or prolonged company. When an outbreak has been discovered, high priority is recommended for contacts having close or prolonged exposure.

Environment promoting transmission. A small interior space with poor ventilation can act as the focus of intense transmission of *M. tuberculosis*. High priority is recommended for all contacts who spent time with an outbreak source patient in such spaces, even if the periods of exposure were brief or unknown.

Certain larger environments (e.g., a warehouse worksite or a school bus [128,129]) have been reported as sites of intensive transmission when patients were highly contagious or when patients and contacts were in prolonged company. If the evidence from the investigation indicates a link between the site and transmission in an outbreak, the contacts in such a site should be designated as high priority, regardless of the site's characteristics.

Contacts very susceptible to disease after *M. tuberculosis* infection. Urgency is required when outbreak cases are diagnosed in contacts who are relatively more susceptible to progression from *M. tuberculosis* infection to TB disease. Other contacts with similar susceptibility should be sought. If such an outbreak includes children aged <5 years, a source-case investigation should be undertaken if the contagious source is unknown initially (see Source-Case Investigations). Intensified methods for active case finding among contacts are recommended.

Gaps in contact investigations and follow-up. Omissions, errors, and system failures can resurface later in the form of secondary TB cases (i.e., an outbreak). Tracing back cases in an outbreak indicates whether prevention opportunities were missed in previous contact investigations or other prevention activities (e.g., targeted testing).

Extra-virulent strain of *M. tuberculosis*. The existence of such strains has not been demonstrated. Determining which strains are more infective or pathogenic for humans is not yet possible, and the relevance of greater/faster pathogenicity of certain strains in laboratory animals is not fully understood yet (58,128,130).

Congregate Settings

Overall concerns associated with congregate settings include 1) the substantial numbers of contacts, 2) incomplete information regarding contact names and locations, 3) incomplete data for determining priorities, 4) difficulty in maintaining confidentiality, 5) collaboration with officials and administrators who are unfamiliar with TB, 6) legal implications, and 7) media coverage. Certain settings require intensified onsite approaches for ensuring that contacts are completely evaluated and for meeting objectives for treating LTBI. Requests for supplemental resources are recommended when the scope or duration of an investigation is expected to disrupt other essential TB control functions.

Maintaining confidentiality for an index patient is difficult if the patient was conspicuously ill or was absent from the setting while ill (see Data Management and Evaluation of Contact Investigations). Permission should be sought from the index patient before sharing information with any officials (e.g., supervisors, managers, or administrators) at the setting.

In contrast with the statement above, CDPH/CTCA recommends that the following would be more appropriate: It is optimal to discuss with the index patient in advance how the LHD staff will share information with any officials (e.g., supervisors, managers, or administrators) at the setting and to seek the patient's input. Whenever possible, and for the purpose of maintaining a cooperative relationship with the patient, local health department staff should take into account the patient's input and preferences about how the notification should occur. If the index case is unwilling or unable to cooperate, the health officer has the authority to carry out contact investigation as necessary to protect the health of the public. (California Health and Safety Code sections 120175 and 121365).

Addendum 47

LACDPH/TBCP supports CDPH/CTCA Addendum 47. Congregate settings often require greater resources and epidemiologic expertise. Consider consulting the LAC DPH TBCP before performing any mass screening to ensure that resources are being appropriately utilized. Such situations may require a more refined approach, where high and medium priority contacts are further stratified into tiers, based on practical concerns and available resources.

Collaboration with officials at the setting is essential for obtaining access to employee and occupancy rosters, ascertaining contacts, performing onsite diagnostic evaluations or treatment, and offering education to associates (e.g., classmates, friends, or coworkers) of the index patient.

For congregate settings, the types of information for designating priorities are site specific, and therefore a customized algorithm is required for each situation. The general concepts of source-case characteristics, duration and proximity of exposure, environmental factors that modify transmission, and susceptibility of contacts to TB should be included in the algorithm (see Decisions to Initiate a Contact Investigation, Index Patient and Sites of Transmission, and Assigning Priorities to Contacts).

The optimum approach for a setting-based investigation is to interview and test contacts on site. If this is not possible, then the contacts should be invited for evaluation at the health department, which should consider having additional personnel or extended hours. As a last resort, contacts can be notified in writing to seek diagnostic evaluation with their own health-care providers. In this case, the letter should inform health-care providers regarding the TB exposure (including drug susceptibility results), diagnostic methods (including a 5 mm skin test cut point), treatment recommendations for LTBI, and a reference telephone number at the health department for obtaining consultation. Health-care providers also should receive a form for each contact that can be used to return diagnostic results and treatment decisions to the health department.

Certain congregate settings create opportunities for efficient onsite supervision of treatment for numerous contacts. Treatment can be delivered by having health department personnel visit the setting twice weekly for intermittent therapy, or by collaborating with a health professional hired by the setting. Arrangements are needed to maintain confidentiality with this approach. Officials and administrators at the setting are likely to be concerned regarding liability, which can be addressed in advance with legal counsel.

For constructive media coverage, the health department should collaborate with the setting in focusing on clear, consistent information. News reports that are factually accurate and that correctly describe the role of the health department can facilitate the investigation (see Communicating Through the News Media).

Correctional Facilities

The Advisory Council for the Elimination of Tuberculosis (ACET) has issued guidance on preventing and controlling TB in correctional facilities ([131](#)). Jails and prisons have been implicated in TB outbreaks ([132–135](#)). Multiple factors can hinder contact investigations. The best preparation for conducting contact investigations in jails and prisons is preexisting formal collaboration between correctional and public health officials. If collaboration has not been established before a contact investigation is needed, creating it as part of the investigation is necessary.

CDPH/CTCA suggests that each LHD identify a correctional liaison consistent with CDPH funding requirement. A duty statement for the correctional liaison is available from the CDPH-TBCB. CDPH/CTCA Joint Guidelines for the Coordination of TB Prevention and Control by Local and State Health Departments and California Department of Corrections can be found at <http://www.ctca.org/guidelines/IIB5coordination.pdf>

The Protocol for Responding to an Outbreak of Communicable Disease within the California Department of Corrections and Rehabilitation may provide guidance for contact investigations in correctional facilities.

<http://www.cdph.ca.gov/programs/ccih/Pages/GuidelinesforCommunicationandResponseToaCommunicableDxOutbreakwithinCDCR.aspx>

The Curry International TB Center has developed a facilitator guide for TB contact investigation in jails.

http://www.currytbcenter.ucsf.edu/products/product_details.cfm?productID=WPT-13

Addendum 48

LAC DPH TBCP – If the index case is in a county jail, CHS staff should work with the TBCP jail LPHN to obtain any necessary information regarding the index case.

For directory of CA correctional facilities or CA TB Programs

http://www.ctca.org/index.cfm?fuseaction=page&page_id=5071

Certain correctional populations have a high prevalence of HIV infection, and reviewing the HIV testing policies, procedures, and aggregate statistics is recommended. If inmates have not been offered voluntary counseling, testing, and referral for HIV infection, and TB exposure is suspected, offering voluntary HIV counseling, testing, and referral is strongly recommended.

Inmates move about within correctional facilities on both daily and weekly schedules that can affect TB exposures. In addition, inmates are transferred within and between jails or prisons. Certain correctional settings have convenient, comprehensive longitudinal records for the locations of inmates that are essential for drawing up contact lists, estimating exposure periods, and assigning priorities to contacts. A tour of exposure sites within each setting helps in estimating exposure intensity.

Prisons typically have onsite health services, but jails might not. Certain prisons and jails test new inmate admissions and employees for *M. tuberculosis* infection, and certain prisons have periodic surveillance testing of employees, inmates, or both. Health-care providers in an onsite system can provide invaluable assistance in reviewing health records and evaluating and treating contacts. If medical record data (e.g., previous exposure and skin test results) cannot be retrieved rapidly, health department officials should consider requesting additional resources.

Investigations in jails can be especially challenging because of rapid turnover of inmates and crowding. The number of contacts who had close proximity to an index patient/inmate can be great, and yet exposure might be brief. This complicates the process of assigning priorities. Unless tracking records for inmates who were in a confined space with an infectious TB patient allow a determination that aggregate exposure was brief (e.g., <8 hours), these contacts should be assigned high priority.

CDPH/CTCA affirms the following statement from the CDC recommendations on “Prevention and Control of TB in Correctional and Detention Facilities”:

“No simple formula has been devised for deciding which contacts to screen in a correctional facility contact investigation. However, the investigation should be guided by the following basic principles:

- **Identified contacts should be stratified by their duration and intensity of exposure to the source patient.**
- **HIV-infected contacts should be classified as the highest priority group for screening and initiation of LTBI therapy, regardless of duration and intensity of exposure.**
- **Identified groups of contacts with the greatest degree of exposure should be screened immediately, followed by repeat testing at 8-10 weeks if the initial TST or IGRA is negative.**
- **The infection rate should be calculated to assess the level of TB transmission.**
- **Decisions to expand the contact investigation to groups with less exposure should be made on the basis of the calculated infection rate. If no evidence of transmission is observed, the investigation should not be expanded. If transmission is occurring, the investigation should be expanded incrementally to groups with less exposure. When the group screened shows minimal or no evidence of transmission, the contact investigation should not be expanded further.**
- **Corrections and medical staff should be included in the contact investigation depending on their exposure risks.”**

Addendum 49

LAC DPH TBCP supports CDPH/CTCA Addendum 49.

High-priority contacts who are transferred, released, or paroled from a correctional facility before medical evaluation for TB should be traced. Unless they have been released or paroled, prison inmates with LTBI can complete a treatment regimen while incarcerated. In contrast, inmates in jails who are contacts are unlikely to be able to complete treatment while incarcerated. A low completion rate is anticipated when inmates are released or paroled unless follow-through supervision can be arranged.

An updated version of the ACET (Advisory Council of Elimination of TB) guidelines, “Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC” can be found at URL:
<http://www.cdc.gov/mmwr/PDF/rr/rr5509.pdf>

Addendum 50

LAC DPH TBCP supports CDPH/CTCA Addendum 50.

Workplaces

A substantial number of persons spend the majority of their waking hours in their workplaces, which can be crowded. Duration and proximity of exposure can be greater than for other settings. Details regarding employment, hours, working conditions, and workplace contacts should be obtained during the initial interview with the index patient (see Investigating the

Index Patient and Sites of Transmission), and the workplace should be toured after accounting for confidentiality and permission from workplace administrators or managers. Employee lists are helpful for selecting contacts, but certain employees might have left the workplace and thus been omitted from current employee lists.

Occasional customers of a business workplace (e.g., intermittent visitors to a fast-food restaurant) should be designated as low-priority contacts. Customers who visit a business workplace repeatedly should be assigned priorities as in other investigations (see Assigning Priorities to Contacts), especially susceptible or vulnerable contacts.

Workplace administrators or managers are likely to express concern regarding liability, lost productivity, and media coverage. In addition, they might have limited obligations to protect patient confidentiality. All these issues can be addressed during planning. For example, the assistance of the health department's media relations specialist can be offered to the workplace. For questions of liability and requirements under law, discussions between the health department's and the workplace's legal counsels are recommended.

Hospitals and Other Health-Care Settings

Nearly every type of health-care setting has been implicated in transmission of *M. tuberculosis*, and guidance on preventing transmission has been provided by CDC, the Healthcare Infection Control Practices Advisory Committee, and other organizations (42,136). State governments

have different degrees of regulatory authority over health-care settings. Personnel collaborating with hospitals and other health-care entities should have knowledge of applicable legal requirements.

In California, healthcare facilities are required to report TB-related events as mandated by Title 17 and Title 22. See Addendum 52.

Addendum 51

Responsibility for Investigation of Exposures in Hospitals and other Health Care Settings

Federal regulations related to Medicare and Medicaid Conditions of Participation assign responsibility to hospitals for maintaining an active program for the prevention, control, and investigation of infections and communicable diseases of patients and personnel and developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel [42CFR 482.42]. In California, State regulations require that local health officers "shall take whatever steps deemed necessary for the investigation and control of the disease, condition or outbreak reported." (17CCR2501, California Health A Safety Code 121365). The California Health and Safety Code does not exclude hospitals from the scope of health officer authority and responsibility.

CDPH/CTCA believes the investigation of TB exposures in hospitals and other healthcare settings is a shared responsibility of the local health department and the individual healthcare facility and that the local health department should provide at least some degree of oversight. The roles and specific division of labor between the healthcare facility and the local health department will likely depend on each healthcare facility's actual capacity and expertise as well as the size and complexity of the investigation. CDPH/CTCA recommends that local health departments seek assistance from their County Counsel for legal advice or a legal interpretation of Federal or State regulations.

References:

CDC. Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005. MMWR 2005;54 (No. RR-17): 1-141

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>

CDPH/CTCA Joint Guidelines to Monitor and Control TB in California Long Term Health Care Facilities, October 2005 http://www.ctca.org/fileLibrary/file_43.pdf

Addendum 52

LAC DPH TBCP supports CDPH/CTCA Addendum 51 and 52 and have provided a table in Chapter 6 of the TB Control Manual (see Special Circumstances) to aid in conducting investigations in health care facilities.

Infection control practitioners, although vital partners in these settings, might not be familiar with TB contact investigations. Multiple settings have engineers who can describe and test the environmental systems. Such an investigation should be planned jointly as a collaboration between the setting and the health department. Initial discussions should include data sharing and divisions of responsibilities. Liability, regulations, confidentiality, media coverage, and occupational safety are complex for health-care settings. Occupational Safety and Health Administration rules, which are interpreted differently by different jurisdictions, might require hospital administrators to report when employees are reported to be infected from occupational exposure. Public health officials should consider inviting legal counsel to the initial planning sessions with health-care administrators.

The majority of health-care settings have policies for testing employees for *M. tuberculosis* infection at the time of employment and, in settings where exposure is anticipated, periodically thereafter. Test results are helpful as baseline data. The availability of baseline results for contacts who were patients or clients of the setting is variable; long-term care facilities might have these data.

Schools

Information, resources and tools for planning and implementing a thorough school contact investigation are available through the CDPH-TBCB's Contact Investigation in Schools Toolkit. This can be found at <http://www.cdph.ca.gov/programs/tb/Pages/ResourcesLHDsTBCB.aspx> under the "Tools and Training" section.

Addendum 53

LAC DPH TBCP- Certain resource/materials found in above reference have been adapted for LAC use. CHS CI Core Team should use correspondence approved by LAC DPH External Relations and consult LAC DPH CHS Administration and TBCP if there are any questions.

This category includes child care centers, preschools, primary through secondary schools, vocational schools that replace or immediately follow secondary school, and colleges or universities. Contact investigations at juvenile detention centers and adult education systems

should be managed along the same lines as investigations conducted in correctional settings and in workplaces, respectively.

Early collaboration with school officials and community members is recommended when considering an investigation related to a school, even if preliminary information suggests that an investigation is unnecessary. The typical features of contact investigations in schools are the potentially substantial numbers of contacts and difficulties in assigning priorities to contacts who have undetermined durations and proximities of exposure. The potential is great for controversies among public health officials, school officials, and the guardians of the children.

The presence of TB in schools often generates publicity. Ideally, the health department should communicate with the school and parents (and guardians) before any media report a story. TB control officials should anticipate media coverage and plan a collaborative strategy (see *Communicating Through the News Media*).

Consent, assent, and disclosure of information are more complex for nonemancipated minors than for adults. Each interaction with a minor is also a potential interaction with the family. The health department typically has limited alternatives for evaluating a minor if permission is not granted. Anticipatory legal consultation is recommended.

Public health officials should visit the school to check indoor spaces, observe general conditions, and interview maintenance personnel regarding ventilation. Class assignment records help in listing contacts, estimating durations of exposure, and setting priorities. However, certain schools purge these files at the end of each school year, in which case interviews with students and personnel are necessary to list contacts.

Extramural activities add other exposure sites and contacts. Clubs, sports, and certain classes require additional information gained from interviewing the patient, the patient's guardians, and school personnel. For patients who ride school buses, a bus company might keep a roster of riders with addresses.

The strategy for contact investigations in child care centers, preschools, and primary schools depends on whether the index patient is a child (i.e., preadolescent) or an adult (e.g., a teacher or caregiver). The potential infectiousness of an adult in the school should be determined (see *Decisions to Initiate a Contact Investigation and Investigating the Index Patient and Sites of Transmission*).

In a source-case investigation of a child aged <5 years who has TB and who attends preschool or child care, all adults in these settings should be included if the source case has not been located in the family or household (see *Source-Case Investigations*). Certain home-based child care centers include adults who do not provide child care but who still share airspace with the children. Source-case investigations should not be pursued in primary and higher-level schools unless other evidence points to the school as the focus.

In secondary and higher levels of education, students usually have adult-form TB, and infectiousness can be estimated by the standard criteria (see *Decisions to Initiate a Contact Investigation and Investigating the Index Patient and Sites of Transmission*). With advancing

education, academic schedules and extramural social schedules become more complex, and the information reported by the index patient is more important for a thorough investigation than it is for younger children.

Multiple jurisdictions have pre-employment requirements for TB clearance screening (e.g., a test for *M. tuberculosis* infection) at schools or daycare settings, and certain jurisdictions require TB clearance for entering students. Certain colleges and universities also have these requirements. These baseline data are helpful for interpreting results from the investigation.

Schools that have onsite health services can administer DOT to students with LTBI, or the health department can send workers twice weekly to provide intermittent therapy. This approach should be coordinated with the annual school cycle.

School breaks, vacations, graduations, and transfers disrupt the contact investigation. In collaboration with school officials, the health department can notify, by mail, students and other contacts who will be unavailable at the school. These contacts should be referred for evaluation at the health department. Contacts seeking care from their own health-care providers should receive written instructions to give their providers.

Shelters and Other Settings Providing Services for Homeless Persons

See resource available through Curry International TB Center, Shelters and TB: What Staff Need to Know, Second Edition

http://www.nationaltbcenter.ucsf.edu/products/product_details.cfm?productID=EDP-11

Addendum 54

LAC DPH TB CP supports CDPH/CTCA Addendum 54. Contact LAC DPH TB CP for assistance with contact investigation at shelters and other settings providing services for homeless persons.

ACET and CDC have provided guidance for providing TB control services to homeless persons and for preventing TB transmission at settings providing services to them ([137](#)). The challenges that can be anticipated for a contact investigation involving a homeless TB patient include difficulty locating the patient and contacts if they are mobile, episodic incarceration, migration from one jurisdiction to another, psychiatric illnesses (including chemical dependency disorders) that hinder communication or participation, and preexisting medical conditions (in particular, HIV infection). When names or locations of specific contacts are unknown, interviews with the patient and potential contacts should focus on social networks and settings, including correctional facilities.

One surrogate for degree of exposure at an overnight shelter is the bed/cot assignment. The proximity and duration of overlap should be estimated as closely as possible for selecting high-priority contacts. Certain daytime-use settings keep sign-in lists, but these might lack information regarding overlap of visits.

Homeless persons frequently seek health care from multiple volunteer providers, halfway houses, chemical dependency treatment programs, community clinics, urgent care centers, and hospital emergency departments. Consultation and assistance from health-care providers in these systems can be helpful. This also creates an opportunity for collaboration, contact ascertainment, and mutual education.

Site visits and interviews are crucial, because the social communities of homeless persons are likely to vary by situation. A contact investigation presents an opportunity to review the screening and testing services and to offer assistance with these and other means of decreasing transmission of *M. tuberculosis* (e.g., environmental controls). However, transmission also could occur at sites besides shelters (e.g., jails, taverns, abandoned buildings, and cars).

Settings providing services to homeless persons are affected by policies, laws, and regulations according to their service population, location, and funding sources, and certain of these issues are relevant for the contact investigation. Access to visitation and occupancy rosters (or logs) and to other information regarding persons, vital for listing contacts and determining priorities, might be restricted by law (e.g., at settings that provide treatment for substance-abuse disorders), and the terms of access should be negotiated.

Low treatment-completion rates have been reported for treatment of LTBI diagnosed at homeless shelters ([137–140](#)). TB control officials should work with setting administrators to offer onsite supervised intermittent treatment. Sites with more stable populations are likely to benefit most from this approach.

Transportation Modes

Transmission of *M. tuberculosis* has been confirmed on military vessels at sea, commercial aircraft, passenger trains, and school buses (85,129,141–144). However, transmission is unlikely unless ventilation is restricted or exposure is long or repetitive. Investigations for these settings should be assigned low priority unless ventilation is restricted or single-trip exposure time is >8 hours (cumulative if the trip has multiple segments) as currently recommended for commercial airline travel, or at least two separate trips were taken with the index patient (145).

CDPH/CTCA recommends consulting with CDPH-TBCB, CDC and WHO due to the complex nature of airline exposures

Addendum 55

LAC DPH TBCP – Consult with LAC DPH TBCP for airline exposures.

Drug or Alcohol Usage Sites

Shared sites of drug or alcohol usage (e.g., taverns and crack houses), have been implicated as sites of *M. tuberculosis* transmission (146, [147](#)). Potential factors are close person-to-person proximity, repetitive exposure, and poor ventilation. Routine interviews might not generate a complete contact list for these settings, and the patient's social network should be explored for other information sources. Connections to correctional settings should be sought. HIV infection is associated with multiple forms of substance abuse, and HIV counseling, testing, and referral services are recommended.

Special Sites Not Under Jurisdiction

Examples of sites that are not under the jurisdiction of the local or state health department are those under the jurisdiction of the U.S. government (e.g., military bases), diplomatic missions, or reservations for American Indian/Alaska Native tribes. If these sites have their own health-care systems, the health department can offer technical consultation and can request data from contact investigations. At sites that do not have health-care systems, agreements can be made between local TB control officials and the onsite authorities to delegate the public health response to the health department.

CDPH/CTCA recommends that local health departments dealing with TB in Native American or Alaskan Native communities should consult with the Health Officer Practice Guide for Communicable Disease Control in California <http://www.cdph.ca.gov/programs/dcdc/Documents/Health-Officer-Practice-Guide-DCDC.pdf>

“Native American tribes have the right to make and be governed by their own laws. However, this does not exclude all state regulatory authority on the reservation. State sovereignty does not end at a reservation’s border.

1. Disease Outbreak That Threatens to Spread Beyond The Reservation.

When state interests outside the reservation are implicated, states may regulate the activities even of tribe members on tribal land. Thus, if an outbreak of disease within the borders of a reservation threatens to spread beyond its borders, a Health Officer may be able to enforce orders within those borders.

2. Validity and Enforcement of Health Officer Orders Issued While Individual is Outside the Reservation.

It is also well established that states have criminal jurisdiction over reservation Indians for crimes committed off the reservation. Thus, if a tribal member is subjected to an order of isolation outside the reservation, then violates that order and returns to the reservation, the state would have criminal jurisdiction over that individual.”

Addendum 56

LAC DPH TBCP supports CDPH/CTCA Addendum 56

Index Patient Unable to Participate

Approximately 8% of pulmonary TB patients with AFB detected on sputum microscopy have no contacts listed (17, 50). TB patients who have few or no contacts listed are more likely to be homeless or to have died (i.e., before an interview could be conducted). This implies that the patients might have had contacts, but learning who the contacts were is difficult. Social-network information, setting-based investigations, and proxy methods are recommended to supplement the contact list. In addition, any person in whom a case of pulmonary TB was diagnosed at death indicates that a possible delay in diagnosis has occurred, which could infer increased and prolonged infectiousness and a need to increase the scope of the investigation.

MDR TB

The occurrence of MDR TB does not change recommendations for assigning contact priorities. Special consideration should be given to instances when resistance is acquired during treatment or when drug resistance was detected late during the treatment course, because these patients might have had prolonged periods of infectiousness. Treatment regimens for infected contacts require expert consultation (see Treatment for Contacts with LTBI) (6).

See resource referenced, [Drug Resistant Tuberculosis: A Survival Guide for Clinicians, Second edition, available through Francis J. Curry National TB Center.](#)

Addendum 57

LAC DPH TBCP supports CDPH/CTCA Addendum 57. LAC DPH TBCP requires that CHS staff contact LAC TBCP MDR unit for expert consultation on every suspect or case of MDR/XDR TB.

Interjurisdictional Contact Investigations

Contact investigations that overlap multiple jurisdictional areas require joint strategies for finding contacts, having them evaluated, treating the infected contacts, and gathering data. A different solution usually is required for each situation.

CDPH-TBCB can assist with interjurisdictional communication and follow-up and the CDPH-TBCB Patient Locating Service can assist with difficult to locate out-of-jurisdiction contacts.

<http://www.cdph.ca.gov/programs/tb/Pages/ResourcesLHDsTBCB.aspx>

CDPH/CTCA Interjurisdictional Continuity of Care Guidelines can be found at

http://www.ctca.org/fileLibrary/file_47.pdf

Addendum 58

LAC DPH TBCP recommends that CHS staff follow the current LAC instructions for International, Interjurisdictional, and Cure TB Notification.

TBCP intranet site

<http://intranet/ph/PHDirector/ChiefDeputyDirector/CommunDiseaseCtrlPrev/TBControl/TB.htm>

TBCP Internet site – under the heading ‘For Health care Professionals-Forms’

<http://publichealth.lacounty.gov/tb/healthpro.htm>

Multiple jurisdictions within the United States. The index patient and associated contacts might have stable residences, but travel among sites in different jurisdictions. The health department that counts the index patient is responsible for leading the investigation and notifying the health departments in other jurisdictions regarding contacts residing in those jurisdictions. Notifications should include requests for follow-through results of contact evaluation and treatment. A team of representatives from the multiple health departments can increase the efficiency of such an investigation by planning the overall strategy together and monitoring the progress.

The jurisdiction of residence of a contact is responsible for evaluation and management of that particular contact, however, contacts associated with a TB case located in another jurisdiction are counted and reported by the jurisdiction reporting the TB case, not the jurisdiction in which the contact is located.

CDPH instructions for counting and reporting contacts by local jurisdictions can be found in the Basic Instructions for the California Aggregate Reports for Tuberculosis Program Evaluation: Follow-up and Treatment for Contacts to Tuberculosis Cases, Preliminary and Final Reports (CDPH, 2007, p. 5)

<http://www.cdph.ca.gov/programs/tb/Documents/TBCB-ARPE-Forms-Instructions.pdf>

The NTCA Interjurisdictional TB Notification system facilitates and standardizes interstate communication to enhance continuity and completeness of care of suspects, cases and contacts. NTCA interjurisdictional notification recommendations and referral forms can be found at:

<http://www.tbcontrollers.org/resources/interjurisdictional-transfers/#.UddwOXvn8dk>

Addendum 59

LAC DPH TBCP supports CDPH/CTCA Addendum 59 and recommends that CHS staff follow the current LAC instructions for International, Interjurisdictional, and Cure TB Notification.

TBCP intranet site

<http://intranet/ph/PHDirector/ChiefDeputyDirector/CommunDiseaseCtrlPrev/TBControl/TB.htm>

TBCP Internet site – under the heading ‘For Health care Professionals-Forms’

<http://publichealth.lacounty.gov/tb/healthpro.htm>

Migratory workers. ACET has issued specific TB prevention and control recommendations for migratory agricultural workers (148). An investigation for any migratory workers requires a

strategy that is adjusted to their migration and work schedule. The workers' itinerary should be ascertained during initial planning, and health departments in successive destinations should be notified. A selection from among three general types of contact record management is recommended: 1) the transfer of patient records from one health department to the next on the itinerary; 2) the continual referral of information to a single coordinating health department throughout the investigation; or 3) patient ownership of records, with each patient responsible for keeping information while moving. Because of the duration of treatment, treating LTBI is the most difficult phase. Certain seasonal workers remain in one place as long as several months during off-season, and this period should be used to deliver as much treatment as possible.

Contagious TB patient traveling within the United States. Officials from the health department that initially encountered the patient should interview the patient to gather as much identifying and locating information as possible for contacts who were visited during the patient's travels. These data should be referred to the jurisdictions in which the contacts are located. The jurisdiction that counts the index patient is assigned responsibility for managing the contact investigation overall.

International contact investigations. The United States and Mexico participate in the Referral System for Binational TB Patients Pilot Project, which coordinates follow-up care when a TB patient moves between these two countries, mainly between participating jurisdictions. Cure TB also contributes to continuity of care in other regions of the two countries. Neither of these systems includes contact investigations at present. TBNet is a health-care system for migratory agricultural workers who are receiving treatment for LTBI and thus includes contacts. For cases or contacts in Canada, U.S. health departments should notify TB control coordinators in provincial health departments.

Unusual Events Causing Exposure to *M. tuberculosis* Complex

The normal mode of transmission is person to person by the airborne route. Unusual events (e.g., laboratory accidents) also can cause *M. tuberculosis* transmission. In contrast, *M. bovis* transmission usually occurs via infected dairy products, which is preventable by pasteurization.

Animals with human-type or bovine TB. Multiple mammalian and certain nonmammalian species are susceptible to human-type TB, presumably through exposure to persons with TB who are contagious. Multiple animal hosts also can contract bovine TB (i.e., infection with *M. bovis*), probably from exposure to other infected animals or from consuming infected dairy products or contaminated feed.

Standard methods for diagnosing *M. tuberculosis* infection and disease have not been described for the majority of species. Evaluation and management of an animal exposed to *M. tuberculosis* should be referred to a veterinarian, who can consult with the state veterinarian. Animal-to-human transmission of human TB in a household has not been confirmed, and the human contacts should be designated as low priority. However, determining the source of *M. tuberculosis* infection for an animal with TB is recommended.

The degree of risk for aerosol-inducing procedures (e.g., intubation, bronchoscopy, or necroscopy) performed on an animal having TB is unknown. However, these procedures are likely to create infectious aerosols. If infection control precautions for preventing *M. tuberculosis* transmission were not implemented during the procedures, then in-room contacts are assigned high priority.

The evaluation and management of animals exposed to *M. bovis* should be referred to a veterinarian. Cases of *M. bovis* in animals should be reported to the state veterinarian. Animal-to-human transmission of *M. bovis* from necropsy procedures has been confirmed (149).

In California, *M. bovis* in cattle must be reported to the California Department of Food and Agriculture

http://www.cdffa.ca.gov/ahfss/animal_health/pdfs/CA_reportable_disease_list_poster.pdf

Addendum 60

LAC DPH TBEP supports CDPH/CTCA Addendum 60.

Patients who *acquire M. bovis* infection from ingestion are more likely to have extrapulmonary TB (e.g., scrofula or peritonitis), but pulmonary disease is possible. Contact investigations regarding persons who have pulmonary TB caused by *M. bovis* should be planned according to the guidelines provided in this report. However, the potential for transmission is less clear. Current and proposed tests for infection (e.g., the TST and QuantiFERON®-TB Gold [QFT-G, manufactured by Cellestis Limited, Carnegie, Victoria, Australia]) detect *M. bovis* infection, but the tests are not approved specifically for this indication. After active *M. bovis* disease has been excluded by symptom review, examination, and tests as indicated by findings, suspected latent *M. bovis* infection should be treated as ordinary *M. tuberculosis* infection.

Multiple laboratory mammals, especially nonhuman primates, are highly susceptible to human-type TB. Federal animal welfare regulations administered by the U.S. Department of Agriculture (<http://www.nal.usda.gov/awic/legislat/awicregs.htm>) apply to laboratory animals and certain animals used in exhibitions. If such animals are exposed to infectious TB, consultation with the state veterinarian is recommended.

Microbiology laboratory accidents. Routine laboratory procedures for manipulating either patient specimens or cultured isolates of *M. tuberculosis* generate infectious aerosols. Unintentional events (e.g., spills outside containment areas) and system failures can cause exposure. A contact investigation for such scenarios should be based on the location of persons in the room at the time of the event and the airflow in the room. Consultation with a microbiologist is recommended. In general, baseline skin test results are available for workers in laboratories in which *M. tuberculosis* is cultured or kept.

Surgical wounds, abscesses, embalming, and autopsies. Diseased tissues are not typical sources of infection unless procedures create aerosols: water-jet irrigation, dripping fluids, electrical cauterization, and cutting with power tools. If procedures were performed on infected tissues before infection control precautions were instituted, then persons in the room at the time should be designated as high-priority contacts.

Percutaneous inoculations. *M. tuberculosis* can cause infection and local disease in skin or deeper tissue after direct inoculation by a contaminated object. Percutaneous exposure would be highly unusual in anyone except a health-care worker, who should have a previous result from baseline testing for infection. A 9-month INH treatment regimen should be started if the *M. tuberculosis* is likely to be susceptible to it. Treatment should be stopped if a repeat test for *M. tuberculosis* is negative >8 weeks after exposure, and treatment should be extended to the full course if the test result is positive. If the baseline test result was positive, the full 9 months of treatment is recommended. During treatment, the person should be examined monthly for signs of local infection or spread to regional lymph nodes.

Transmission through organ transplantation has been recognized and in cases where an organ donor has *M. tuberculosis*, CDPH/CTCA recommends seeking expert consultation in cases of organ transmission.

Addendum 61

LAC DPH TBCP recommends that CHS staff consult with LAC TBCP in cases of suspected TB transmission through organ transplantation.

Source-Case Investigations

A source-case investigation seeks the source of recent *M. tuberculosis* infection, perhaps newly diagnosed TB disease (43). TB disease in children aged <5 years typically indicates that the infection must be recent. For this reason, it is a sentinel public health event. Young children usually do not transmit TB to others, and their contacts are unlikely to be infected because of exposure to them (150). A source-case investigation moves in the opposite direction of contact investigation, but the principles used in contact investigation apply. Source-case investigations concerning adults with TB disease are not discussed in this report (42,131,151).

Source-case investigations typically have low yield for the effort required. They are not recommended unless a TB control program is achieving its objectives (in particular, treatment of infected contacts) when investigating infectious cases.

Source-Case Investigation for a Child with TB Disease

The yield of source-case investigations for children who have TB disease varies, typically <50% on average (152–156). Source-case investigations can be considered for children aged

<5 years. A younger age cut-off might be advisable because the focus would be on more recent transmission. An investigation may be started before the diagnosis of TB is confirmed because waiting for confirmation can decrease the chances of finding associates.

CDPH/CTCA recommends that source case investigations be performed for children under the age of 5 years with active TB disease. While the source case may not always be found, source case investigations can identify undiagnosed TB cases, adults and children with LTBI who would benefit from treatment, and missed opportunities for TB prevention (152, 156).

Addendum 62

LAC DPH TBCP supports CDPH/CTCA Addendum 62.

Source-Case Investigation for a Child with Latent *M. tuberculosis* Infection

CDPH/CTCA acknowledges that the decision to pursue source-case investigations for children with LTBI should be based on local data, experience and resources. If these investigations are being done, local TB control programs should monitor their yield in terms of new TB cases and infected persons identified. Local programs should assess which investigations are most likely to be productive.

Two important factors to consider are the age and country of birth of the child. Local TB programs should also assess the resources required to carry out this type of investigation and determine whether they should be done in light of competing priorities.

http://www.ctca.org/fileLibrary/file_214.pdf

Addendum 63

LAC DPH TBCP recommends CHS staff do not conduct a source case finding for a child of any age diagnosed with LTBI.

A search for the source of infection for a child who has LTBI is unlikely to be productive (157–159). These kinds of investigations are recommended only regarding infected children aged <2 years and only if data are monitored to determine the value of the investigation.

Procedures for Source-Case Investigation

Seeking a source case follows the same overall procedures as a standard contact investigation. Parents or guardians usually are the best informants. Such persons are termed

associates. Attention focuses on ill associates who have symptoms of TB disease. A source-case investigation should begin with the closest associates (e.g., household members).

Limited data are needed for assessing the productivity of source-case investigations. These data include the number of index patients investigated for their sources, the number of associates screened for TB disease, and the number of times that a source is found.

Other Topics

Cultural Competence

Culture refers to the integrated pattern of knowledge, beliefs, and behavior that is passed from one generation to another (160), including how persons act and interact. If contact investigations are to be productive, cultural differences must be respected and understood. Cultural competence is the knowledge and interpersonal skills that allow health-care providers to appreciate and work with persons from cultures other than their own. It involves awareness of cultural differences, self-awareness, and sensitivity to a patient's culture and adaptation skills.

Language and culture are important factors in TB contact investigations. The ability to understand cultural norms and to bridge the gaps that exist between cultures requires training and experience. Influencing patients to participate in a contact investigation increasingly depends on the cultural competency of the health-care worker. Training that is derived from the National Standards for Culturally and Linguistically Appropriate Services in Health Care is recommended (161).

Language interpreters need basic knowledge regarding TB, transmission, contact investigations, and the medical care of contacts. Patient confidentiality is a critical element of training. The use of family-member interpreters is discouraged. The majority of family members do not have a medical orientation. Patients might feel reluctant to reveal contacts of a family member.

See CDPH/CTCA addendum 44 for cultural competency training resources.

Addendum 64

LAC DPH TBCP-see LAC specific addendum to CDPH/CTCA Addendum 44.

Social Network Analysis

Social network analysis might offer an effective way to list TB contacts and assign priorities to them (162–166). Social network analyses have been tested retrospectively on TB outbreak investigations (126, [167–170](#)) and contact investigations (171, 172). However, the use of social

network analysis to improve contact investigations has not been tested prospectively, the methods might require additional labor, and further operational research is needed.

Use of Blood Tests for the Detection of Latent *M. tuberculosis* Infection

The majority of experience with diagnosing *M. tuberculosis* infection, especially LTBI, in contacts has been with the TST. Newly released blood tests now have potential use for this purpose. The initial QuantiFERON[®]-TB test (QFT) is a whole blood assay that measures IFN-gamma release in response to purified protein derivative (PPD). Good agreement was reported with the skin test in healthy adults being tested for LTBI, and QFT was approved by the U.S. Food and Drug Administration (FDA) (173,174). Data are insufficient to demonstrate the accuracy of QFT test for testing contacts, and it was not recommended for this situation (175).

Recently, QFT-G was approved by FDA for use as an in vitro diagnostic to aid in diagnosing *M. tuberculosis* infection, including both LTBI and TB disease. This test detects the release of IFN-gamma from lymphocytes of sensitized persons when their blood is incubated with peptide mixtures simulating two *M. tuberculosis* proteins called ESAT-6 and CFP-10. These proteins are secreted by all *M. tuberculosis* and pathogenic *M. bovis* strains, but are absent from all BCG vaccine strains and commonly encountered non-tuberculous mycobacteria. Therefore, QFT-G offers the possibility of detecting *M. tuberculosis* infection with greater specificity than has been possible previously with tests that used tuberculin PPD as the TB antigen (175,176).

CDC recommends that QFT-G can be used in all circumstances in which the TST is currently used, including contact investigations (177). QFT-G can be used in place of and not in addition to the TST. A positive QFT-G result should prompt the same evaluation and management as a positive TST. No reason typically exists to follow a positive QFT-G with a TST. For persons with recent contact to infectious TB, negative QFT-G results typically should be confirmed with a repeat test performed 8–10 weeks after the end of exposure. Studies to identify the most appropriate times to re-test contacts with QFT-G have not been reported. Until more specific data are available, the timing of QFT-G testing should be similar to that used for the TST.

Concern has been expressed that the QFT-G test might be somewhat less sensitive than the TST in detecting LTBI (177). As with a negative TST, a negative QFT-G result alone should not be used to exclude *M. tuberculosis* infection in severely immunosuppressed adults, children aged <5 years, or patients about to undergo treatment with TNF- α inhibitors, in whom the consequences of accepting a false-negative result could be especially severe.

Another blood test for detection of infection, the ELISPOT test (marketed as T-SPOT-TB), is similar in principle to QFT (ELISPOT results correlate with TB exposure risk better than skin test results for contacts of pulmonary TB patients), and like QFT-G, it appears able to differentiate between BCG vaccination and *M. tuberculosis* infection (178,179). The T-Spot TB test was approved by FDA in 2008.

CTCA position statement for the use of QuantiFERON-TB Gold can be found at http://www.ctca.org/guidelines/CTCA_QFT_Position_Statement.pdf

Addendum 65

LAC DPH TBCP- Refer to the updated CDPH/CTCA Interferon Gamma Release Assays Clinical Guidelines in California can be found at http://www.ctca.org/fileLibrary/file_374.pdf

Additional resources regarding tuberculosis (TB) contact investigations are available from the following organizations:

- CDC, National Center for HIV, STD, and TB Prevention, Division of Tuberculosis Elimination (available at <http://www.cdc.gov/nchstp/tb>)
 - Self-Study Modules on Tuberculosis 6–9 [Module 6: Contact Investigations]
 - Effective TB Interviewing for TB Contact Investigations
 - Effective TB Interviewing for Contact Investigation: Facilitator-Led Training Guide
 - Effective TB Interviewing for Contact Investigation: Facilitator-Self-Study Modules
 - Patient Education Booklet, "Contact Investigations" (Languages: English, Tagalog, Vietnamese, and Spanish)
 - TB Education and Training resources Web Site (available at <http://www.findTBresources.org>);
- New Jersey Medical School Global Tuberculosis Institute (available at <http://www.umdnj.edu/ntbcweb>)
 - Performance Guidelines for Contact Investigation: The TB Interview—A Supervisor's Guide for the Development and Assessment of Interviewing Skills
 - TB Interviewing for Contact Investigation: A Practical Resource for the Healthcare Worker
 - TB Simulated Patients: A Training Resource for the Contact Investigation Interview
 - Performance Guidelines: A Supervisor's Guide for the Development and Assessment of Field Investigation Skills
 - TB Field Investigation: A Resource for the Investigator
 - Conducting a TB-Education Session as Part of the Congregate Setting Investigation
 - Evaluating Congregate Setting Investigations in Tuberculosis Control;
- Charles P. Felton Model TB Center (available at <http://www.harlemtbcenter.org>)
 - Addressing HIV/AIDS Issues in TB Contact Investigations;
- Curry International Tuberculosis Center (available at <http://www.nationaltbcenter.ucsf.edu/index.cfm>)
 - Contact Investigation in a Worksite Toolbox
 - Quality Improvement for TB Case Management: An Online Course

- Making the Connection: An Introduction to Interpretation Skills for TB Control
- Facilitating TB Outreach: Community Workers and Hard-To-Reach TB Populations;
- Southeastern National Tuberculosis Center (available at <http://SNTC.medicine.ufl.edu>);
and
- Heartland National Tuberculosis Center (available at <http://www.heartlandntbc.org/>).

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* The age-cohort effect was strong in this study, but this factor is beyond the scope of these guidelines.

National Tuberculosis Controllers Association/CDC Workgroup on Contact Investigations Membership List, December, 2005

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Appendix A

Glossary

The following terms and abbreviations are used in this report.

Acid-fast bacilli (AFB). Microorganisms that are distinguished by their retention of specific stains even after being rinsed with an acid solution. The majority of AFB in patient specimens are mycobacteria, including species other than *Mycobacterium tuberculosis* complex. A positive nucleic acid amplification (NAA) or culture result is needed for confirmation of *M. tuberculosis* complex. The relative concentration of AFB per unit area on a slide (the smear grade) is associated with infectiousness.

Anergy. A condition wherein a person has diminished ability to exhibit delayed T-cell hypersensitivity reaction to antigens because of a condition or situation resulting in altered immune function. When referring to inability to react to a skin test, the correct term is cutaneous anergy. Skin tests for anergy (i.e., control antigens) have poor predictive value and are not recommended.

Associate contact. A person who is somehow affiliated with a patient who has noninfectious tuberculosis (TB) or with another contact. Often used in connection with source-case investigations; does not imply a *M. tuberculosis* transmission pathway.

Bacille Calmette-Guérin (BCG). A vaccine for tuberculosis named after the French scientists Calmette and Guérin. The vaccine is effective in preventing disseminated and meningeal TB disease in infants and young children. It might have approximately 50% efficacy for preventing smear-diagnosed pulmonary TB in adults. It is used in multiple countries where TB disease is endemic.

Boosting. When nonspecific or remote sensitivity to tuberculin (purified protein derivative [PPD] in the skin test) wanes or disappears with time, subsequent tuberculin skin tests can restore the sensitivity. This is called boosting or the booster phenomenon. An initially limited reaction size is followed by a larger reaction size on a later test, which can be confused with a conversion or a recent *M. tuberculosis* infection. Two-step testing is used to distinguish new infections from boosted reactions in infection-control surveillance programs, but this method is not recommended for testing contacts.

Bronchoscopy. A procedure for examining the lower respiratory tract that requires inserting the end of an endoscopic instrument through the mouth or nose (or tracheostomy) and into the respiratory tree. It can be used to obtain diagnostic specimens. It also creates a high risk for *M. tuberculosis* transmission to health-care workers if it is used on a patient who has TB (even if the patient is smear negative), because the procedure induces coughing.

Bronchoalveolar lavage (BAL). A procedure for collecting respiratory specimens from the airway, typically during bronchoscopy. Sterile saline is flushed through an airway, and the resultant mixture of cells, secretions, and saline is aspirated for studies (e.g., microscopy and culture).

Case. A particular instance of a disease (e.g., TB). A case is detected, documented, and reported.

Cavity (pulmonary). A hole in the lung parenchyma, typically not involving the pleural space. Although multiple causes can account for a lung cavity, and its appearance is similar regardless of its cause, in pulmonary TB, it results from the destruction of pulmonary tissue by direct bacterial invasion and an immune interaction triggered by *M. tuberculosis*. A tuberculous cavity large enough to see with a normal chest radiograph predicts infectiousness.

Contact. Refers to someone who has been exposed to *M. tuberculosis* infection by sharing air space with a person with infectious TB.

Contagious. Refers to TB disease of either the lungs or the throat that has been demonstrated to have caused transmission to other persons or the patient who has TB disease.

Conversion. Standard - A change in the result of a test for *M. tuberculosis* infection that is interpreted to indicate a change from being uninfected to infected. With the tuberculin skin test, an increase of ≥ 10 mm in induration size during ≤ 2 years is defined as a conversion. A conversion is presumptive evidence of new *M. tuberculosis* infection and poses an increased risk for progression to TB disease. **TST conversion for contacts:** Defined differently from a standard skin test conversion. For contacts, a skin test conversion is defined as an increase of at least 5mm, from less than 5mm on the initial skin test to a reaction of greater than or equal to 5mm on the second test, 8 to 10 weeks after exposure.

Delayed-type hypersensitivity (DTH). Cell-mediated inflammatory reaction to an antigen that is recognized by the immune system, typically because of previous exposure to the same or similar antigens. Cell-mediated reactions are contrasted with an antibody (or humoral) response. DTH typically peaks 48–72 hours after exposure to the antigen.

Directly observed therapy (DOT). An adherence-enhancing strategy in which a health-care worker or other trained person watches a patient swallow each dose of medication and is accountable to the public health system. DOT is the preferred method of care for all patients with TB disease and is a preferred option for patients under treatment for latent infection.

Disseminated TB. See Miliary TB.

Tuberculosis disease with simultaneous involvement of multiple organs. Commonly referred to as miliary because of the appearance in the involved tissues of an immense number of small, 1-2-mm, well defined nodules. This miliary pattern may be seen antemortem only on chest x-ray. However, a considerable proportion of patients who present with disseminated multiorgan tuberculosis do not have these characteristic findings.

(Adapted from Iseman, Michael, MD. 2000. A Clinician's Guide to Tuberculosis. Lippincott Williams & Wilkins, Philadelphia, PA.)

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Drug-susceptibility test. A laboratory determination to assess whether an *M. tuberculosis* complex isolate is susceptible or resistant to anti-TB drugs that are added to mycobacterial growth medium. The results predict whether a specific drug is likely to be effective in treating TB disease caused by that isolate.

Enabler. A practical item given to a patient for making adherence (e.g., to treatment or to clinic appointments) easier.

Exposure. The condition of being subjected to something (e.g., an infectious agent) that could have an effect. A person exposed to *M. tuberculosis* does not necessarily become infected. Much of the work in a TB contact investigation is dedicated to learning who was exposed and, of these, who became infected.

Exposure period. The coincident period when a contact shared the same air space as a person with TB during the infectious period.

Exposure site. A location that the index patient visited during the infectious period (e.g., a school, bar, bus, or residence).

Extensively drug-resistant TB (XDR-TB). A strain of TB that is resistant to isoniazid, rifampin, a fluoroquinolone, and at least one of three injectable second-line drugs (amikacin, kanamycin, or capreomycin). From MMWR, 2006; 55 (43):1176.

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Immunocompromised and immunosuppressed. Conditions in which at least part of the immune system is functioning at less than normal capacity. According to some style experts, immunocompromised is the broader term, and immunosuppressed is restricted to conditions with iatrogenic causes, including treatments for another condition. Some immunocompromised conditions increase the likelihood that *M. tuberculosis* infection will progress to TB disease. Certain conditions also make TB disease or infection from *M. tuberculosis* more difficult to diagnose because manifestations of TB disease differ, and tests for infection rely on an intact immune system.

Incentive. A gift given to patients to encourage or acknowledge their adherence to treatment.

Index. The first case or patient that comes to attention as an indicator of a potential public health problem. Contrast with Source.

Induration. The firmness in the skin test reaction. Induration is produced by immune-cell infiltration in response to tuberculin antigen that was introduced into the skin. It is measured by palpation transversely, and the result is recorded in millimeters (mm). The measurement is compared to guidelines to determine whether the test result is classified as positive or negative.

Infection. A condition in which microorganisms have entered the body and typically have elicited immune responses. *M. tuberculosis* infection might progress to TB disease. The expression *M. tuberculosis* infection includes both latent infection and TB disease. Latent *M. tuberculosis* infection or latent tuberculosis infection (LTBI) is an asymptomatic condition that follows the initial infection; the infection is still present but is dormant (and believed not to be currently progressive or invasive). TB disease is determined by finding anatomic changes caused by advancing infection (e.g., shadows from infiltrates on a chest radiograph) or by noting symptoms (e.g., malaise, feverishness, or cough), and typically by both. Positive culture results for *M. tuberculosis* complex typically are interpreted as both an indication of TB disease and its confirmation, but infecting organisms can be obtained from patients who have no other evidence of disease.

Infectious. Refers either to TB disease of the lungs or throat, which has the potential to cause transmission to other persons, or to the patient who has TB disease.

Infectious period. The time during which a person with TB disease might have transmitted *M. tuberculosis* organisms to others. The infectious period typically is defined as 12 weeks before TB diagnosis or onset of cough (whichever is longer). If a patient has no TB symptoms, is AFB-smear negative, and has a non-cavitary chest radiograph, the presumed infectious period can be reduced to 4 weeks before the date of diagnosis of suspected TB. If the contact investigation indicates that TB transmission occurred throughout the identified infectious period, the time for contact investigation might need to be expanded. From Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations from CDC, MMWR 2006.

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Interferon- γ Release Assay (IGRA). An in-vitro, blood based diagnostic test that measures the cell mediated immune response to *M. tuberculosis* antigens. The presence of such a response is suggestive of infection with *M. tuberculosis*. [QuantiFERON[®]-TB Gold In-tube](#) or [T-Spot](#) are IGRAs.

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Isoniazid (INH). A highly active anti-TB chemotherapeutic agent that is a basis of treatment for TB disease and latent infection.

Laryngeal TB. A highly infectious form of TB disease, with erosive, exudative invasion of the larynx.

Latent *M. tuberculosis* infection (or latent tuberculosis infection [LTBI]). See Infection.

Mantoux method. A skin test performed by intradermally injecting 0.1 mL of PPD tuberculin solution into the volar or dorsal surface of the forearm. This is the recommended method for tuberculin skin testing.

Meningeal TB. A highly dangerous and difficult-to-diagnose form of TB disease with infectious invasion of the tissues covering the brain. Often indolent but uniformly fatal if untreated, at times it is diagnosed too late to save the patient's life or prevent permanent disability.

Miliary TB.

See “Disseminated TB”

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Sometimes referred to as disseminated TB. A dangerous, and difficult to diagnose, form of rapidly progressing TB disease that extends throughout the body. Uniformly fatal if untreated, sometimes it is diagnosed too late to save a life. Derives its names from a pathognomonic chest radiograph, but certain patients with this condition have normal findings or ordinary infiltrates on the chest radiograph.

Molecular Beacon. Real-time PCR technology that provides identification of *M. tuberculosis* complex and screening for INH and rifampin resistance within 1-3 days. The molecular beacon test used in the California State Microbial Disease Laboratory (MDL) has a high specificity for identification of *M. tuberculosis* complex in acid fast bacilli smear positive specimens or growth from solid media or MGIT and is also able to identify common genetic mutations associated with isoniazid and rifampin resistance.

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LAC DPH TBCP see Addendum 7

Multidrug-resistant TB (MDR TB). TB disease caused by an *M. tuberculosis* strain that is resistant to at least INH and rifampin. Treatment regimens for curing MDR TB are long, expensive, and difficult to tolerate. The cure rate depends on the susceptibility of *M. tuberculosis* to alternative chemotherapy.

***Mycobacterium bovis* (*M. bovis*).** A member organism of *M. tuberculosis* complex and the causative infectious agent of TB in cattle. It also causes infection and disease in humans, who

become infected by consuming unpasteurized dairy products from tuberculous cows. Human *M. bovis* TB disease has certain distinctive characteristics but in practical terms is indistinguishable from human-variant TB. Human pulmonary *M. bovis* TB disease probably is transmissible to other humans by the airborne route, and secondary cases can result, especially among vulnerable contacts.

Mycobacterium tuberculosis (M. tuberculosis). The namesake member organism of *M. tuberculosis* complex, and the most common causative infectious agent of TB disease in humans. At times, the species name refers to the entire *M. tuberculosis* complex, which includes *M. bovis* and five other related species.

Nucleic acid amplification (NAA). A laboratory method used to target and amplify a single DNA or RNA sequence for detecting and identifying (typically) a microorganism. NAA tests for *M. tuberculosis* complex are sensitive and specific; they can accelerate confirmation of pulmonary TB disease.

Purified protein derivative (PPD) tuberculin. A material used in diagnostic tests for *M. tuberculosis* infection. In the United States, PPD solution (5 tuberculin units per 0.1 mL) is approved for administration as an intradermal injection as a diagnostic aid for *M. tuberculosis* infection (latent infection or TB disease). PPD tuberculin also was one of the antigens in the first-generation QuantiFERON-TB test.

QuantiFERON[®]-TB test. An in vitro cytokine assay that detects cell-mediated immune response (see also DTH) to *M. tuberculosis* in heparinized whole blood from venipuncture. This test requires only a single patient encounter, and the result can be ready ≤ 1 day. In 2005, QuantiFERON[®]-TB is being replaced by QuantiFERON[®]-TB Gold, which has greater specificity because of its synthetic antigens. QuantiFERON[®]-TB Gold appears capable of distinguishing between the sensitization caused by *M. tuberculosis* infection and that caused by BCG vaccination.

Radiography. The diagnostic imaging techniques (including plain-film chest radiographs and computerized tomography) that rely on degrees of X-radiation transmission related to differences in tissue densities.

Secondary (TB) case. A new case of TB disease that is attributed to recent (i.e., <2 years) transmission as part of a scenario under investigation. Technically, all cases are secondary, in the sense that they arise from other cases that are contagious.

Secondary (or "second-generation") transmission. Transmission of *M. tuberculosis* from persons with secondary cases (see Secondary (TB) case). This creates a chain of transmission, and if secondary transmission is identified as part of a contact investigation, the scenario can be classified as an outbreak.

Smear. A laboratory technique for preparing a specimen so bacteria can be visualized microscopically. Material from the specimen is spread onto a glass slide (and typically dried and stained). Smear, stain, and microscopy methods for mycobacteria are specific to this genus (see AFB). The slide can be scanned by light or fluorescent high-power microscopy.

These methods require ongoing quality assurance for prompt and reliable results. The results for sputum AFB smears typically are reported as numbers of AFB per high-powered microscopy field, or else as a graded result, from no AFB to 4+ AFB. The quantity of stained organisms is associated with degree of infectiousness.

Source case or patient. The case or person that was the original source of infection for secondary cases or contacts. The source case can be, but is not necessarily, the index case.

Specimen. Any bodily fluid, secretion, or tissue sent to a laboratory for testing.

Sputum. Mucus containing secretions coughed up from within the lungs. Tests of sputum (e.g., smear and culture) can confirm pulmonary TB disease. Sputum is different from saliva or nasal secretions, which are unsatisfactory specimens for detecting TB disease. However, specimens suspected to be inadequate should still be processed because positive cultures can still be obtained and may be the only bacteriologic indication of disease.

Suspected TB. A tentative diagnosis of TB that will be confirmed or excluded by subsequent testing. Cases should not remain in this category for >3 months.

Symptomatic. A term applied to a patient with health-related complaints (i.e., symptoms) that might indicate the presence of disease. At times, the term is applied to a medical condition (e.g., symptomatic pulmonary TB).

TB disease. See discussion under Infection.

Treatment for LTBI. Treatment that prevents the progression of infection into TB disease.

Tuberculin. A precipitate made from a sterile filtrate of *M. tuberculosis* culture medium.

Tuberculin skin test (TST). A diagnostic aid for finding *M. tuberculosis* infection. A small dose of tuberculin (see also Mantoux method and PPD) is injected just beneath the surface of the skin by the Mantoux method, and the area is examined for induration by palpation 48–72 hours after the injection. Indurated margins should be read transverse (perpendicular) to the long axis of the forearm.

Tuberculin skin test conversion. See Conversion.

Tuberculosis (TB). A clinically active, symptomatic disease caused by infection with a member of the *M. tuberculosis* complex.

Two-step (tuberculin) skin test. A procedure used for baseline skin testing of persons who will periodically receive TSTs (e.g., health-care workers or residents of long-term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second test is repeated 1–3 weeks later. If the reaction to the second TST is positive, it probably represents a boosted reaction, indicating that the infection was most likely in the past and not recent. If the second TST is also negative, the person is classified as not being infected. Two-step skin testing has no place in contact investigations or in other circumstances in which ongoing transmission of *M. tuberculosis* is suspected.

Appendix B:

Specific Investigation Plan

Contact Investigation Case Conference and Supervisory Oversight

Specific contact investigation plans ensure prompt identification of contacts, timely evaluation and treatment of contacts, and efficient use of local resources; Tuberculosis (TB) Controller review and supervisory oversight are essential to this process. Case conference/contact investigation meetings also provide a forum for frequent reassessment of contact investigation progress and evidence-based decision making. A multidisciplinary team approach encourages active participation in the contact investigation process and ensures essential information is not omitted in the case-by-case assessment.

- I. **Contact Investigation Case Conference: Contact Investigation Team** (public health nurse supervisor (PHNS), the TB chest clinician, and the Area Medical Director)
 - A. Weekly contact investigation meetings allow for review of all AFB smear and culture positive pulmonary/laryngeal/pleuro-pulmonary TB cases within 5-7 working days of report date.
 - B. Information should be organized and presented in a consistent format to facilitate review, and, at a minimum, should include:
 1. Data collected from case reports, medical records, laboratories and healthcare providers:
 - a. Onset and duration of signs and symptoms
 - b. Chest radiograph/CT-scan results
 - c. Acid-fast smear, culture and susceptibility results as well as nucleic acid amplified tests (NAAT), PCR, molecular beacon and genotyping results (when available)
 - d. Start date of TB medication regimen, and information regarding toleration of medication, whether self-administered or DOT
 - e. Medical conditions/treatment that might impact TB treatment adversely, or have implications for contacts (e.g. renal dialysis)
 2. Information from index case and contact interviews, including (but not limited to) social and leisure activities, travel, and recent employment history (see Table 4 for a complete list of recommended data)
 3. Results of home evaluations and site visits
 4. Contact roster(s) (see [Table 5](#) for minimal data recommended concerning each contact of persons with TB)

5. Initial TB screening results (if available) for household contacts
- C. Based on the information presented, the Contact Investigation Team:
1. Determines infectious period
 2. Determines exposure settings
 3. Determines the exposure period for each exposure setting
 4. Establishes the scope of the investigation
 5. Assigns priorities to contacts
 6. Makes recommendations for medical evaluation and treatment of contacts
 7. Establishes timeframes for initiation and completion of TB screening activities
 8. Report TB suspect/case to TBC any index case with a pulmonary, laryngeal or pleural TB site of disease and one of the following indicators of infectiousness: sputum AFB smear positive, Cavitory Chest X-Ray, positive Nucleic Acid Amplification Test or Culture positive for M.tb. Refer to the joint CHS and TBC 'TB Contact Investigation Monitoring and Communication Standards' for additional details.
- D. The contact investigation plan of action, and subsequent updates and revisions, should be documented in the patient's public health record.
- E. Periodic updates of ongoing contact investigations should include review of statistical analyses of TB screening results (calculate infection rates), and reporting of new findings such as secondary cases and drug-resistant susceptibility patterns, or specific problems related to the case or the contacts. Epidemiological data provide the basis for reports to, and consultation with, CDPH TB Control Branch Outbreak Response Team—if indicated.
- F. Contact investigation review meetings should include quality assurance activities such as 60 and 90-day reviews of persistently AFB sputum smear-positive cases. Discussions regarding contact investigation accomplishments, challenges and reviews of possible treatment failure should also be held.

II. Supervisory Oversight

- A. In general, clinical supervisors coordinate and provide oversight of case management and contact investigation activities. Clinical supervisors establish a structure for contact investigation activities that ensures efficient and timely response to TB Controller recommendations and optimal use of resources. The clinical supervisor:
1. Develops written policies and procedures to guide TB case management and contact investigation activities

2. Educates and trains staff and regularly assesses competency; pays particular importance to training in cultural competency and interview techniques
3. Develops tools for organization and tracking of information
4. Ensures equipment and supplies are maintained
5. Assigns responsibility for all elements of a contact investigation: Develops an individual plan, based on TB Controller recommendations, for each contact investigation, with clear written instructions for nursing and ancillary staff
6. Deploys staff, monitors workflow and allocates additional resources if needed
7. Acts as a liaison between TB Controller, public health personnel, providers, and, when applicable, other involved individuals in the community
8. Monitors progress of contact investigations
9. Provides leadership to public health personnel
10. Ensures contact investigation data are forwarded to designated staff (ideally, TB program epidemiologist) for analysis